CONTRACT

BETWEEN

WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES
DIVISION OF DISABILITY and ELDER SERVICES

AND

PARTNERSHIP PLAN

2006

Wisconsin Department of Health and Family Services

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CONTRACT WITH
PARTNERSHIP PLAN

To Serve Medicaid-Only and Dual Eligible Participants
Under the
Wisconsin Partnership Program
Protocol

PREAMBLE

The Wisconsin Department of Health and Family Services/Division of Disability and Elder Services (the Department), and Partnership Plan, Inc., a Managed Care Organization (MCO) health care insurer with a certificate of authority or a waiver of licensure from the Office of the Commissioner of Insurance to do business in Wisconsin, and an organization which makes available to enrolled participants, in consideration of periodic fixed payments, comprehensive health and long-term care services provided by providers selected by the organization and who are employees or partners of the organization or who have entered into a referral or contractual arrangement with the organization, for the purpose of providing and paying for Medicaid contract services to recipients enrolled in the MCO, under the State of Wisconsin Medicaid Plan approved by the Secretary of the United States Department of Health and Human Services (DHHS) pursuant to the provisions of the Social Security Act and for further specific purpose of promoting coordination and continuity of preventive health services and other medical care including emergency care, do herewith agree with the following terms of the contract.

This contract applies to Partnership Plan, Inc., 90347 Wisconsin St., Anywhere, WI 54999, as the provider of integrated and comprehensive services to participants in the Wisconsin Partnership Program (Partnership).

The term of this contract shall be from January 1, 2006, through December 31, 2006.[1]

This contract describes desired outcomes, how it will be determined that the desired outcomes have been delivered, and standards of operations for contractors of the Wisconsin Partnership Program and the State of Wisconsin Department of Health and Family Services/Division of Disability and Elder Services, in relationship to Wisconsin Partnership Program contractors.

[1] See 42 CFR 422.504, "*Effective Date and Term of the Contract*."

ARTICLE I

DEFINITIONS

Terms that are not defined below shall take their meaning from the relevant portions of the Social Security Act (42 U.S. C. ss. 1396 et. seq.), and HFS 101 through 108.

Action. The term “action” shall mean:

a. The denial or limited authorization of a requested service, including the type or level of service;
b. The reduction, suspension, or termination of a previously authorized service;
c. The denial, in whole or in part, of payment for a service;
d. The failure to provide services in a timely manner, as defined by the State; or,
e. The failure of the MCO to act within the timeframes provided in 42 CFR 438.408(b).

Adverse Action Date. The phrase “adverse action date” means the day during a given month when ten (10) days advance notice must be sent to a member before reducing or terminating benefits, so as to assure that the member has the notice in hand at least ten (10) days before the end of the month. Benefits are always reduced or terminated at the end of a month (unless the benefit is ending because the person died or the person has demanded immediate disenrollment). In a thirty-one (31) day month, adverse action is generally on the 18th; in a thirty (30) day month, it's on the 17th.

Appeal. The term “appeal” means a request for review of an action.

Balanced Workforce: An equitable representation of persons with disabilities, minorities and women available for jobs at each job category from the relevant labor market from which the recipient recruits job applicants. (Wisconsin Contract Compliance Law, Chapters 16.765.)

CMS. The term “CMS” refers to the Federal Center for Medicare & Medicaid Services.

Community-Based Organization. The term “community-based organization” means a nonprofit agency providing community-based health services such as nutritional support, health check screening, family planning, targeting such services to high risk populations.

Complaints. The term “Complaints” means an expression of dissatisfaction about any matter other than an action. The terms “Complaint” and “Grievance” are synonymous.
Cultural Competency. The term “cultural competency” means a set of congruent behaviors, attitudes, practices, and policies that enable providers to relate to the participant and to provide care with sensitivity, understanding, and respect for the member’s culture. The related elements of cultural competence include understanding the dynamic of difference, institutionalizing cultural knowledge, valuing diversity, and adapting to and encouraging organizational diversity.

Department. The term "Department" means the Wisconsin Department of Health and Family Services.

Dialysis. The term "dialysis" refers to a process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semi permeable membrane. The two types of dialysis that are currently in common use are hemodialysis and peritoneal dialysis.

Dual Coverage. The term "dual coverage" refers to services that are covered by both the Federal Medicare Program and the Wisconsin Medicaid Program.

Dual Eligible. The term "dual eligible" refers to an individual who meets the requirements to receive benefits from both the Federal Medicare Program and the Wisconsin Medicaid Program. "Dual eligibility" does not guarantee "dual coverage."

Eligibility. The term "eligibility" may refer to the Federal Medicare Program, the Wisconsin Fee-For-Service (FFS) Medicaid Program, and/or the Partnership Program. As it relates to the Federal Medicare Program and the Wisconsin Medicaid Program, the term "eligibility" is defined by Federal and State statutes and regulations. As it relates to participation in the MCO's Partnership Program, the term "eligibility" refers to individuals who meet all of the following criteria:

a. Persons who are at least 18 years of age at the time of enrollment;
b. Mississippi County residency;
c. Eligibility for Medicaid or under provisions approved by CMS for the Partnership waiver;
d. Functionally eligible as determined via the Long-term Care Functional Screen prior to enrollment and annually thereafter; and,
e. Medicare eligible applicants to the Partnership program must have both Medicare Part A and Part B to be eligible for enrollment. Once current enrollees become eligible for Part A and Part B they must obtain that coverage as soon as possible. In the situation where an enrolled member becomes eligible for Medicare Part A and B benefits and refuses to enroll in either Part A or B, the member becomes ineligible and the Partnership sites must disenroll them and notify them of their appeal rights.

Additional Requirements for Enrollment. The MCO may not enroll in the Partnership Program:

a. Persons applying for Partnership enrollment who are dually-eligible for Medicaid and Medicare with a diagnosis of End Stage Renal Disease;
b. and, a person who has a less than six month life expectancy is not eligible for enrollment.

Emergency Medical Condition. The term "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
b. Serious impairment to bodily functions.

Serious dysfunction of any bodily organ or part.

Emergency Dental Care. Emergency dental care is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma.

Emergency Services. The term "emergency services" means covered inpatient and outpatient services that are: (a) furnished by a provider that is qualified to furnish these services under this title; and (b) needed to evaluate or stabilize an emergency medical condition.

End Stage Renal Disease. The term "End Stage Renal Disease" is abbreviated "ESRD" and means that the stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

Enrollee. The term "enrollee" means a Medicaid recipient who has been certified as eligible to enroll under this contract, and whose name appears on the Managed Care Organization's (MCO) Enrollment Reports, which the Department will transmit to the MCO every month in accordance with an established notification schedule.

Enrollment Area. The term "enrollment area" means the geographic area in which recipients must reside in order to enroll in the MCO under this contract.

Enrollment Report. The term, "Enrollment Report" means the document that the Department transmits monthly to the MCO in accordance with the notification schedule set forth in Addendum XV.

Experimental Surgery and Procedures. The term "experimental" means services that the Department considers "not to be proven and effective" treatment for the conditions for which it is intended to be used, including transplant surgeries exclusive of cornea and kidney transplants.

Fraud. The term "fraud" means an intentional deception or misrepresentation made by a person or entity with the knowledge that the deception or misrepresentation could result in some unauthorized benefit to him/herself, itself or to some other person or entity. It includes any act that constitutes fraud under applicable Federal or State law.

Home and Community-Based Waiver Services. This term means services covered under the either Wisconsin Community Options Program and the Wisconsin Community Integration Program.

Intensive Skilled Nursing Level of Care. The term Intensive Skilled Nursing (ISN) level of care means care requiring specialized nursing assessment skills and the performance of specific services and procedures that are complex because of the member's condition or the type or number of procedures that are necessary.

Long-Term Care Functional Screen (LTC-FS). The LTC-FS refers to the tool, approved by CMS and the Department, used to determine nursing home level of care.

Marketing Materials. "Marketing materials and other marketing activities" include the production and dissemination of any promotional material in all mediums, including Evidence of Coverage, brochures and leaflets, newspaper, magazine, radio, television, billboards, and Yellow Pages advertisements, and presentation materials used by marketing representatives that are mailed to, distributed to or aimed at Medicaid and Medicare recipients specifically, and any material that mentions Medicaid or Medicaid Assistance or Title XIX (Medical Assistance to low-income persons).

MCO. The term "MCO" means the Manage Care Organization, a private, nonprofit non-stock s. 501(c)(3) Wisconsin corporation that administers the Wisconsin Partnership Program.

Medically Necessary. The term "Medically Necessary" means a service that is "required to prevent, identify or treat a recipient's illness, injury or disability." Medical necessity may only be determined by a physician or, where allowed under the Wisconsin Administrative Code, a nurse practitioner, licensed in the State of Wisconsin.

Medicaid. The term "Medicaid" means the Wisconsin Medical Assistance Program operated by the Wisconsin Department of Health and Family Services under the Social Security Act and under chapter 49, Wisconsin Statutes, and under related State and Federal rules and regulations. The term "Medicaid" will be used consistently in the Contract. "Medicaid" is also known as "MA," "Medical Assistance," "WMAP' and "T-19."

Member. The terms "member," "enrollee" and "participant" mean a person who is in the MCO's Partnership program. (See Definition of Enrollee.)

Memorandum of Understanding. The term "Memorandum of Understanding" or "MOU" means an agreement detailing the actions of two parties under circumstances specified in the agreement.

Nursing Home Level of Care. The term "Nursing Home Level of Care" means a level of care provided in a nursing facility and reimbursable under the Medicaid program.

Protected Health Information. The term "Protected Health Information" or "PHI" has the same definition as set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations promulgated there under at 45 CFR Parts 160 through 164.

Partnership. The term "Partnership" means the Wisconsin Partnership Program (WPP) as further described in CMS's approval of the Partnership demonstration waiver of October 16, 1998.

Participant. The term "participant" has the same meaning as the term "enrollee," which is defined above.

Physical Disability. The term “Physical Disability” means “a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly interferes with or significantly limits at least one major life activity of a person.”

Post-eligibility Treatment of Income. This term means the contribution toward the cost of services by consumers required as a condition of eligibility. This term is commonly referred to as “cost share” in Wisconsin.

Post Stabilization Services. The term “Post Stabilization Services” means services related to an emergency medical condition that are either: (a) provided after an enrollee is stabilized in order to maintain the stabilized condition; or (b) provided to improve or resolve the enrollee's condition; coverage of Post Stabilization Services is defined under Article IV of this Contract.

Potential Member or Potential Enrollee. The term, means an MA recipient who is eligible to voluntarily enroll in WPP, but is not yet an enrollee.

Protocol. The term “Protocol” means the current protocol that serves as a legal instrument for the implementation of this Contract. Under this Contract, the Partnership Protocol is that one approved by CMS and the Department on December 21, 2004 or as amended in collaboration with the MCO and approved by CMS.

Provided Services. The term “provided services” shall include all non-purchased services that the Partnership Organization provides in order to deliver and coordinate health and long-term care services. These services include, but are not limited to the following:

- Health care services and case management services provided by a Nurse Practitioner employed by the Partnership Organization to a specific member;
- Health care services and case management services provided by a Registered Nurse employed by the Partnership Organization to a specific member;
- Health care services and case management services provided by a Social Service Coordinator (or Social Worker) employed by the Partnership Organization to a specific member;
- Personal care services provided by a the Partnership Organization employed Certified Nursing Assistant to a specific member;
- Personal care services provided by a Daily Living Attendant/Personal Care Worker/Supportive Home Care Worker employed by the Partnership Organization to a specific member;
- Therapy and case management services provided by a Physical Therapist employed by the Partnership Organization to a specific member;
- Therapy and case management services provided by an Occupational Therapist employed by the Partnership Organization to a specific member;
- Therapy and case management services provided by a Speech Therapist employed by the Partnership Organization to a specific member;
- All transportation services (trips) the Partnership Organization provides to members;

- All durable medical equipment the Partnership Organization provides to members; and,

All disposable medical supplies the Partnership Organization provides to members.

Purchased Services. The term "purchased services" means services provided to a Partnership member for which the Partnership Organization receives a request for payment.

Public Institution. The term "public institution" has the same meaning as set forth in Wisconsin Administrative Code HFS 107.03(15).

Recipient. The term "recipient" means an "enrollee" or "member" in the MCO's programs. (See definition of "*Enrollee.*")

Requirements for Enrollment of Dual-Eligibles. The MCO can only enroll persons who are dually eligible for Medicaid and Medicare when those persons agree to receive their Medicare managed care benefits through the MCO. In addition, the MCO shall disenroll dual-eligible members who decide to receive Medicare managed care benefits (other than Medicare Hospice benefit) from another provider.

Risk. The term "risk" means the possibility of the MCO's monetary loss or gain resulting from service costs exceeding or being less than capitation payments made to it by the Department.

Risk Reserve. The term "risk reserve" means a segregated fund account that the MCO establishes to ensure continuity of care for its enrolled members, accountability to taxpayers, solvency protection against financially catastrophic cases, and effective program administration.

Subcontract. The term "subcontract" means any written agreement between the MCO and another party to fulfill the requirements of this contract. However, such term does not include insurance purchased by the MCO to limit its loss with respect to an individual enrollee.

Third Party Liability. The term "Third Party Liability" or "TPL" refers to the situations set forth at 42 USC. s.1396a(a)(26)(2001).

Transport by Common Carrier. Common carrier means any mode of transportation approved by a county or tribal agency, except an ambulance or a Specialized Medical Vehicle (SMV).

Urgent Care. The term "urgent care" is defined at Wisconsin Administrative Code Ins. 9.38.

ARTICLE II

DELEGATIONS OF AUTHORITY

A. Outcome

The MCO is accountable for any and all functions and responsibilities that it delegates to any subcontractor including overseeing the quality of services provided by subcontractors.

1. Outcome is met when the MCO:

    a. Acquires and maintains written agreements with subcontractors that:

        i. Specify the delegated activities and responsibilities; and,
        ii. Provide for revocation of the delegation or imposition of other sanctions if a subcontractor's performance is inadequate.

    b. Maintains oversight of subcontractors' quality of services within the MCO's internal Quality Assurance/Quality Improvement (QA/QI) program;
    c. Demonstrates compliance through submission of the reports and/or updates to the Department per the Reporting Requirements in Addendum IV; and,
    d. Delegation of Authority Review.

ARTICLE III

FUNCTIONS AND DUTIES OF THE MANAGED CARE ORGANIZATION

Contents:

A. Outcome

The MCO meets and maintains the basic requirements to perform the functions and duties under this contract.

The outcome is met when the MCO retains the authority to operate, assures ethical standards, discloses potential conflicts of interest, and complies with other listed State and Federal standards.

B. Relationship with the Office of the Commissioner of Insurance

The MCO is required to retain at all times during the period of this contract a valid Certificate of Authority issued by the State of Wisconsin office of the Commissioner of Insurance or obtain a waiver of licensure from the Office of the Commissioner of Insurance.

C. Assure Ethical Standards

The MCO is required to promote the following ethical standards:

1. Management Subcontracts. The Department will review the MCO's subcontracts for management operations and systems to assure that rates are reasonable.

    a. Compensation for Services. Subcontracts for MCO management must clearly describe the services to be provided and the compensation to be paid.
    b. Compensations. Any potential bonus, profit-sharing, or other compensation not directly related to costs of providing goods and services to the MCO, shall be identified and clearly defined in terms of potential magnitude and expected magnitude during the MCO contract period.
    c. Reasonableness. Any such bonus or profit sharing shall be reasonably compared to services performed. The MCO shall document reasonableness.
    d. Specific Maximum Amount. A maximum dollar amount for such bonus or profit sharing shall be specified for the contract period.

2. Subcontracts – Disclosure of Interest. The MCO agrees to submit to the Department within thirty (30) days of contract signing, full and complete information as to the identity of each person or corporation with an ownership or controlling interest in the MCO, or any subcontractor in which the MCO has a five (5) percent or more ownership interest.

    a. Definition of "Ownership or Control Interest." A "person with an ownership or control interest" means a person or corporation that:

        i. Owns, directly or indirectly, five (5) percent or more of the MCO's capital or stock or receives five (5) percent or more of its profits;
        ii. Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the MCO or by its property or assets, and that interest is equal to or exceeds five (5) percent of the total property and assets of the MCO; or,
        iii. Is an officer or director of the MCO (if it is organized as a corporation) or is a partner in the MCO (if it is organized as a partnership).

    b. Calculation of Five (5) Percent Ownership or Control. The percentage of direct ownership or control is the percentage interest in the capital, stock or profits. The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns ten (10) percent of the stock in a corporation which owns eighty (80) percent of the stock of the MCO, the person owns eight (8) percent of the MCO. The percentage of ownership or control through an interest in a mortgage, deed or trust, note or other obligation is calculated by multiplying the percent of interest which a person owns in that obligation by the percent of the MCO's assets used to secure the obligation. Thus, if a person owns ten (10) percent of a note secured by sixty (60) percent of the MCO's assets, the person owns six (6) percent of the MCO.
    c. Information to be Disclosed. The following information must be disclosed:

        i. The name and address of each person with an ownership or controlling interest of five (5) percent or more in the MCO or in any subcontractor in which the MCO has direct or indirect ownership of five (5) percent or more;
        ii. A statement as to whether any of the persons with ownership or control interest is related to any other of the persons with ownership or control interest as spouse, parent, child, or sibling; and,
        iii. The name of any other organization in which the person also has ownership or control interest. This is required to the extent that the MCO can obtain this information by requesting it in writing. The MCO must keep copies of all of these requests and responses to them, make them available upon request, and advise the Department when there is not response to a request.

d. Reported Information on Disclosure. This information may already have been reported on Form CMS-1513, "Disclosure of Ownership and Control Interest Statement." Form CMS-1513 is likely to have been completed in two different cases. First, if the MCO is federally qualified and has a Medicare contract, it is required to file Form CMS-1513 with CMS within one hundred twenty (120) days of the MCO's fiscal year end. Secondly, if the MCO is owned by or has subcontracts with Medicaid providers who are reviewed by the State survey agency, these providers may have completed Form CMS-1513 as part of the survey process. If Form CMS-1513 has not been completed, the MCO may supply the ownership and control information on a separate report or submit reports filed with the State's insurance or health regulators as long as these reports provide the necessary information for the prior twelve (12) month period. As directed by the CMS Regional Office (RO), this Department must provide documentation of this disclosure information as part of the prior approval process for contracts. This documentation must be submitted to the Department and the RO prior to each contract period. If the MCO has not supplied the information that must be disclosed, a contract with the MCO is not considered approvable for this period of time and no FFP is available for the period of time preceding the disclosure.

e. Prohibited Providers. A managed care entity may not knowingly have a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non procurement activities as a director, officer, partners, or person with beneficial ownership of more than five (5) percent of the entity's obligations under its contract with the State.

3. Disclosure Statement – Business Transactions. Party-In-Interest. The MCO must disclose to the Department information on certain types of transactions that it has with a "party in interest" as defined in the Public Health Service Act.

    a. Definition of a Party in Interest. As defined in s. 1318(b) of the Public Health Service Act, a party in interest is:

        i. Any director, officer, partner, or employee responsible for management or administration of the MCO; any person who is directly or indirectly the beneficial owner of more than five (5) percent of the equity of the MCO; any person who is the beneficial owner of more than five (5) percent of the MCO; or, in the case of the MCO that is organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;
        ii. Any organization in which a person described in subsection (i) is director, officer or partner; has directly or indirectly a beneficial interest of more than five (5) percent of the equity of the MCO; or, has a mortgage, deed of trust, note or other interest valuing more than five (5) percent of the assets of the MCO;

iii. Any person directly or indirectly controlling, controlled by, or under common control with the MCO; or,
iv. Any spouse, child, or parent of an individual described in subsections (1), (2), or (3).

b. Types of Transactions That Must Be Disclosed. Business transactions, which, must be disclosed include:

i. Any sale, exchange, or lease of any property between the MCO and a party in interest;
ii. Any lending of money or other extension of goods, services (including management services) or facilities between the MCO and the party in interest; and,
iii. Any furnishing for consideration of goods, services (including management services) or facilities between the MCO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

c. The information, which, must be disclosed in the transactions listed in subsection B. between the MCO and a party in interest includes:

i. The name of the party in interest for each transaction;
ii. A description of each transaction and the quantity or units involved;
iii. The accrued dollar value of each transaction during the fiscal year; and,
iv. Justification of the reasonableness of each transaction.

4. Extension Review. If this Contract is renewed or extended, the MCO must disclose information on these business transactions which occurred during the prior contract period. If the Contract is an initial contract with Medicaid, but the MCO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving the Medicaid enrollment. All of these business transactions must be reported.

D. Program Integrity

1. General Requirements. The MCO must have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse. Fraud and abuse must be reported to the State in accordance with 42 CFR 455.17.

2. Specific Requirements. The MCO’s arrangements or procedures must include the following:

a. Written policies, procedures, and standards of conduct that articulates the organization's commitment to comply with all applicable Federal and State standards, including occupational safety and health standards promulgated under the Occupational Safety and Health Act (OSHA) (29 USC; s. 654 et. seq.)
b. The designation of a compliance officer and compliance committee that are accountable to senior management.
c. Effective training and education for the compliance officer and the organization's employees.
d. Enforcement of standards through well-publicized disciplinary guidelines.
e. Provision for internal monitoring and auditing.
f. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's contract with the Department.

E. Long-Term Care Functional Screen

1. The MCO staff who administer the functional screen must meet the following qualifications:

    a. Bachelor of Arts or Science degree, preferably in a health or human services related field, and at least one year of experience working with at least one of the target populations; or,
    b. Prior approval from the Department based on a combination of post-secondary education and experience or on a written plan for formal and on-the-job training to develop the required expertise prepared by the agency; and,
    c. Pass all Screener Certification exams and become certified by the Department as a functional screener before being allowed to administer the functional screen.

2. Screen Quality. Parallel to the screener qualification, training, and certification requirements there are quality performance and assurance requirements to ensure consistency and accuracy of administration of the screen.

3. The MCO shall develop and implement policies and procedures to ensure the accuracy and timeliness of the functional screens done by the MCO. These policies and procedures shall include provisions for the MCO to do all of the following:

    a. The MCO shall designate a staff member who meets all of the requirements to administer the functional screen to be a screen lead. The screen lead shall have the following responsibilities:

        i. Act as the liaison between the Department and the MCO with respect to all of the issues involving the quality of the screens done by the MCO;
        ii. Attend the screen lead meetings held by the Department; and,

iii. Randomly sample completed screens to make sure that they are accurate and complete.

b. All screeners are to read and follow the instructions for the functional screen issued by the Department and all of the updates issued by the Department to these instructions;
c. Train, mentor, and monitor new screeners;
d. Work with the Department to maintain an accurate, complete, and up-to-date list of all of the staff members who are screeners;
e. Consult with the Department about cases where it is proving unusually difficult for the MCO to complete an accurate screen on an individual or to interpret all or part of a completed screen;
f. The screen lead and other screeners shall participate in Department required training for screeners;
g. The screeners shall complete at least once during the effective term of this contract the hypothetical case scenario exercise that the Department creates; and,
h. All screeners shall complete at least once during the effective term of this contract the hypothetical case scenario exercise created by the Department. If the average score for all screeners, or any individual screener, is below seventy (70) percent on any one of the following three screen components:

    i. Activities of daily living;
    ii. Instrumental activities of daily living; and,
    iii. Health related services. The MCO will implement any improvement projects or correction plans the Department requires to ensure the accuracy and thoroughness of the screens.

i. Discuss with the Department what changes, if any, it might need to make in the way that it does its screening if the Department concludes, after analyzing data from screens that the MCO has done, that there are or may be problems with the way it is doing its screening and communicates this conclusion to it in the quarterly reports or in the annual report that the Department prepares on screen data and sends to the MCO or in any other way at any other time.

4. Plans of Correction. The MCO shall submit to the Department for its approval, plans of correction concerning the way its screeners perform their screening in the following circumstances and according to the following provisions.

    a. If the average score for all of the screeners at the MCO on the hypothetical case scenario exercise that the screeners complete at least once during the effective term of this contract is below 70 on the section on activities of daily living or on the section on instrumental activities of daily living or on the section on health-related services, the MCO shall submit a plan of correction indicating how it will improve its screeners' screening;

b. If the average score for all of the screeners at the MCO on the hypothetical case scenario exercise that the screeners complete at least once during the effective term of this contract is 70 or above on any one of the three sections referred to in Paragraph a of this subsection but the actual score of one or more screeners is below 70 on any one of these three sections, the MCO shall submit a plan of correction indicating how it will improve this screener's or these screeners' screening;
c. If the Department believes that there may be problems with the way the MCO is administering the screen the Department may, at its sole discretion, require the MCO to submit a plan of correction indicating how it will improve the accuracy the screens administered by the MCO;
d. In the event that the MCO is required to submit a plan of correction pursuant to paragraphs a, b, or c of this subsection, the Department shall discuss with the MCO the goals of the plan as well as the ways to reach these goals. The Department shall also discuss with the MCO how and when it will be determined that the MCO has fulfilled its obligations under the plan of correction. Finally, the Department shall discuss with the MCO when to set the deadline for the MCO submission of the plan, the deadline for the Department's review of the plan, and the deadlines for any subsequent submissions and reviews. Once the Department approves a plan of correction, the MCO shall implement any and all of its provisions.

F. Federal Conflict of Interest Standards Compliance

1. The MCO is required to meet all requirements of the Byrd Anti-Lobbying Amendment (31 USC 1352) which states that no appropriated funds may be expended by the recipient of a Federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered Federal Actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. The MCO must safeguard against conflicts of interest in accordance with 1932(d)(3).

3. The MCO must comply with the requirements of 45 CFR Part 74, Appendix A.

G. Collection of Cost Share (Post Eligibility Treatment of Income)

1. The MCO is responsible for the collection of cost share as determined by the County, Economic Support Unit. The collection of cost share may not be delegated to any sub-contracted provider.

ARTICLE IV

SERVICE COVERAGE

Contents:

A. Outcome

Provide and/or purchase appropriate amount, duration and scope of medical and social services for Partnership participants.

The outcome is met when there is:

1. Approval of the Provider Network listed in the Provider Directory which meets all requirements specific to this article.

2. Approval of the "Semiannual Narrative Report" which meets all requirements specific to this article.

B. Service Delivery and Treatment – Team Model

The MCO shall provide services through a comprehensive interdisciplinary health and social services delivery system which integrates acute and long-term services pursuant to this contract, state and federal regulations and Partnership protocol. If there is a real or perceived contradiction between the Partnership Operations Protocol language and this contract, then the contract takes precedence.

* 42 CFR 434.6(a)(4) Amount, duration and scope of services

C. General Statement of Coverage

1. The MCO shall be responsible for all services as defined by applicable State and Federal laws and legislation and related periodicals, including:

   * HFS 108.02 (4) and (7) Wisconsin Administrative Code: Provider Handbooks and Bulletins, Mailings and distribution

* Wisconsin Statutes s. 49.46(2): Medical Assistance: Recipients of Social Security Aids and Benefits
* Chapter HFS 107, Covered Services, Wisconsin Adm. Code
* Wisconsin Medicaid Program Provider Handbooks and Bulletins, as updated
* 42 CFR 441-Subpart E Abortions (Report Required)
* 42 CFR 441.202 Abortions Prohibited
* 42 CFR 441 Subpart F Sterilizations and Hysterectomies (Report Required)
* 42 CFR 422.100-105, 112-114: Benefits and Beneficiary Protections Access to Service
* 42 CFR 438.102(a)(2): Objecting to Provision of Service Based on Moral and Religious Grounds
* 42 CFR 438.102(b)(1): Information to send to State if objecting
* 42 CFR 438.114(e): Emergency and Post Stabilization Service Coverage and Payment: This applies to cites below through SSA1932(b)(2)
* 42 CFR 438.114(b), (c)(1)(i), (c)(1)(ii)(A), (c)(1)(ii)(B)
* 42 CFR 438.114(d)(1)(i), (d)(1)(ii)
* 42 CFR 438.114(d)(2), (d)(3)
* 42 CFR 438.206() (d)(3) Second Opinions
* 42 CFR 422.113(c), (c)(2)(i), (c)(2)(ii), (c)(2)(iii), (c)(2)(iv)
* 42 CFR 422.113(c)(3)
* 42 CFR 434.6(a)(4)
* SSA 1852(d)(2)
* SSA 1932(b)(2)
* 42 CFR 438.206(b)(2) (The MCO must provide female enrollees with direct to a women's health specialist within the network for covered care access necessary to provide women's routine and preventative health care services. This is in addition to the enrollee's designated source of primary care if that source is not a woman's health specialist.)
* 42 CFR 438.210(a)(3)(i), (ii) and (iii): Appropriate Amount and Duration of Services Available
* 42 CFR 438.206(b)(1) Delivery Network- Availability of Services
* 42 CFR 438.207 (b) and (c) Documentation and Assurances of Adequate Capacity
* 42 CFR 438.208(b)(2) Primary Care and Coordination of Health Care Services
* 42 CFR 438.210(a)(3)(ii) Coverage of Services
* 42 CFR 438.210 (a)(1) Coverage of Services
* 42 CFR 438.210(b)(3) Denying a Service Authorization
* 42 CFR 438.210(b)(1), (b)(2), (b)(3) Authorization of Services
* 42 CFR 438.210(c) Notice of Adverse Action
* 42 CFR 438.210(d)(1) Time Frame for Decision
* 42 CFR 438.404(c)(3) Time Frames for Notice of Action: Standard Service Authorization Denial
* 42 U.S.C. 1932(b)(3)(B)(i) and (ii): Objecting to Provision of Service Based on Moral and Religious Grounds
* 1915 (c) Waiver: Home and Community-Based Waiver Services
* All exclusions of the demonstration and award letter of October 16, 1998

* SSA 1852: Benefits and Beneficiary Protections
* COP Waiver Manual Chapters 1-9 and Related Appendices
* Partnership Protocol Manual
* Wis. Stats. s. 46.27(11) Medical Assistance Waiver Long-Term Support and Community Options Program
* Current Evidence of Coverage and Disclosure Information
* 42 CFR 438.6(m) Choice of Health Professional
* 42 CFR 438.10(f)(4) Notice on Change of Information
* 42 CFR 438.10(f) (5) Notice of Provider Termination
* 42 CFR 438.52(d), (c) Choice, Limitation on Changes of Primary Care Provider
* 42 CFR 438.6(e) Services that May be Covered

2. The MCO is required to provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

3. The MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

4. The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity or for utilization control provided the services furnished can reasonably be expected to achieve their purpose.

5. The MCO is not required to provide a counseling or referral service if the MCO objects to the service on moral or religious grounds. If the MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

    a. To the Department;
    b. With the MCO's application for a Medicaid contract;
    c. Whenever the MCO adopts the policy during the term of the contract;
    d. It must be consistent with the provisions of 42 CFR 438.10;
    e. It must be provided to potential enrollees before and during enrollment; and,
    f. It must be provided to enrollees within ninety (90) days after adopting the policy with respect to any particular service.

6. Where and when the MCO and its network of providers are unable to provide necessary medical services covered under the contract to a particular enrollee, the MCO must adequately and in a timely manner cover these services out of network for the enrollee for as long as the MCO is unable to provide them. The MCO must coordinate with out-of-network providers with respect to payment.

7. The MCO must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt or issuance of the

termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

8. Post Eligibility Treatment of Income. Post eligibility treatment of income will apply to Partnership services.

9. Experimental Surgery. The MCO will follow the guidelines for experimental surgery and procedures as follows:

    a. The General Principle MCO does not pay for items that Wisconsin Medicaid determines to be experimental in nature. This may include, but not be limited to bone marrow transplants, liver, heart, heart-lung, lung and pancreas. Cornea and kidney transplants are not considered to be experimental in nature.
    b. Process for Transplants in WPP: The MCO will be responsible for services per:

        i. DHFS Memo #4 January 18, 2000 and any subsequent changes
        ii. DHFS Memo #5 June 16, 2000
        iii. Evidence of Coverage
        iv. HSS 107.035 Definition and Identification of Experimental Services
        v. HSS 107.08(2) Services Requiring Prior Authorization
        vi. Wisconsin Partnership Protocol - Manual Excluded Services

    c. The MCO will pay for 'work up' and presurgery expenses.
    d. Exemption. The MCO will continue to provide Medicaid-covered services until one of the following scenarios occurs:

        i. The hospital or transplant provider notifies the MCO that the transplant has been performed. The participant will be permanently disenrolled for Medicaid-covered services effective the date the transplant surgery occurred. In the case of autologous bone marrow transplants, the person will be exempted from enrollment the date the bone marrow was extracted.
        ii. Sixty (60) calendar days have passed since the effective date of Medicare disenrollment. The participant will be disenrolled for Medicaid-covered services in accordance with standard involuntary disenrollment procedures in the Partnership Site Operations Protocol.

    e. Ineligibility for Partnership. Refer to Article VII s. C.(1) regarding eligibility information surrounding transplants.

10. Dental Care Services. Be responsible for certain dental services as per HSS 107.07

11. County Transportation. Be responsible, when applicable, for arranging with County government's participant transportation by common carrier or private motor vehicle that the MCO participants may require.

D. Coordination of 24-Hour Emergency Care

1. The MCO coordinates all emergency contract services and post-stabilization services as defined in this contract twenty-four (24) hours each day, seven (7) days a week, either by the MCO's own facilities or through arrangements approved by the Department with other providers. Services shall include but not be limited to one (1) phone line to receive emergency calls. Individuals with authority to authorize treatment as appropriate must be accessible via this phone number.

2. The MCO is responsible for coverage and payment of emergency services and post stabilization care services. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO in a manner consistent with Medicare and Medicaid regulations. The MCO may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition or when the MCO instructs the member to receive emergency care.

3. The MCO in coordination with the attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO as identified in 42 CFR 438.114(b) as responsible for coverage and payment.

4. The MCO is financially responsible for emergency services and post-stabilization services obtained within or outside the MCO's network that are pre-approved by the MCO.

5. The MCO is financially responsible for post-stabilization care services obtained within or outside the MCO's network that are not pre-approved, but administered to maintain, improve or resolve the enrollee's stabilized condition if:

    a. The MCO does not respond to a request for pre-approval within one (1) hour;
    b. The MCO cannot be contacted; or,
    c. The MCO and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with the MCO care team or medical director. The treating physician may continue with care of the patient until the MCO care team or medical director is reached or one of the criteria in paragraph 7. a. through d., below, is met.

6. Payment for post-stabilization service must be made in a manner consistent with Medicare and Medicaid regulations.

7. The MCO must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MCO. The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

    a. The enrollee's primary care physician assumes responsibility for the enrollee's care;
    b. The enrollee's primary care physician assumes responsibility for the enrollee's care through transfer;
    c. The MCO and the treating physician reach an agreement concerning the enrollee's care; or,
    d. The enrollee is discharged.

E. Urgent Care

MCO members must have access to urgent care services during regular business hours of Urgent Care facility. The Emergency Room (ER) is used when Urgent Care is closed.

F. Provision of Family Planning Services

When applicable, MCO members must have access to family planning services, whether the provider is or is not part of the network. If the participant chooses an out of plan provider, the MCO will reimburse the out of plan provider of those family planning services according to the Wisconsin Medical Assistance Fee-for-Service rule and rates. All such information and medical records relating to family planning shall be kept confidential.

G. Services – Unavailable and Excluded

The MCO shall inform the applicant, on or before an individual enrolls under this Contract, in a written and prominent manner, of any benefits to which the participant may be entitled to under this Contract but which are not available through the MCO. The Partnership Protocol and Evidence of Coverage contain lists of excluded services.

H. Provision of Services

1. Authorizations: The MCO must establish a prior authorization policy that identifies the services that require authorization as well as the process for requesting and granting prior authorizations. This is to include the following time frames.

    a. Authorization Time Frames. Authorization decisions must be made within the following time frames and, in all cases, as expeditiously as the enrollee's condition requires:

        i. Within fourteen (14) days of the receipt of the request; or,

ii. Within seventy-two (72) hours if the physician indicates or the MCO determines that following the ordinary time frame could jeopardize the enrollee's health or ability to regain maximum function.

2. The MCO may be permitted one extension of up to fourteen (14) days if the enrollee requests it or if the MCO justifies the need for more information.

3. Any decision to deny a healthcare related service authorization request or to authorize a healthcare related service in amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Any decision to deny a non-healthcare service must be made by a person with appropriate expertise related to the requested service.

4. The MCO must notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing.

5. Changes in Covered Services. Changes to Medicaid or Medicare covered services mandated by Federal or State law subsequent to the signing of this Contract will not affect the contract services for the term of this Contract, unless: (1) agreed to by mutual consent, or (2) the change is necessary to continue receiving Federal funds, or due to actions of a court of law:

    a. Capitation Adjustment. The Department may incorporate any change in covered services mandated by Federal or State law into the contract effective the date the law goes into effect, if the law adjusts the capitation rate accordingly.
    b. Changes by Mutual Agreement. The Department will give the MCO thirty (30) days notice of any such change that reflects service increases, and the MCO may elect to accept or reject the service increases for the remainder of that Contract year. The Department will give the MCO sixty (60) days notice of any such change that reflects service decreases, with the right of the MCO to dispute the amount of the decrease within that sixty (60) day period. The MCO has the right to accept or reject service decreases for the remainder of the Contract year.
    c. Date of Change Implementation. The date of implementation of the change in coverage will coincide with the effective date of the increased or decreased funding. This section does not limit the Department's ability to modify this Contract due to changes in the State Budget.

6. Changing Primary Providers. The MCO shall inform members that they have the right to change primary providers two times in any calendar year and to change primary providers more often than that for just cause. If the MCO is not able to accommodate an enrollee's choice of primary provider, the enrollee may voluntarily disenroll from the program.

ARTICLE V

PROVIDER NETWORK

Contents:

A. Outcome

The MCO will assure that there is an appropriate range of services and access to preventive and primary care services.

The outcome is met when there is approval of:

1. The MCO's provider network by the Department and CMS.

B. Assuring Approval and Oversight

1. Department's Authority. The Department and CMS have the authority to review, approve, approve with modification, or deny:

    a. Subcontracts under this Contract; and,
    b. Review and approve the MCO's provider network on an annual basis.

        * 42 CFR 434.6(a)(5) Department Oversight

2. General Requirements. The Department and CMS require:

    a. Written Documents. The MCO must assure that all subcontracts shall be in writing, shall comply with the provisions of this Contract and shall include any general requirements of Article V, Provider Network, and assure that all subcontracts shall not terminate legal liability of the MCO under this contract.

The MCO may subcontract for any function covered by this Contract, subject to the requirements of this Article V.

* 42 CFR 438.206(b)(1) Availability of Services – Delivery Network – Written Agreements
* 42 CFR 438.224 Confidentiality
* 45 CFR parts 160 &164 HIPAA
* 42 CFR 438.208(b)(4) Coordination and Continuity of Care
* 42 CFR 434.6(b) and (c)

b. Notices for Discontinuing, Terminating Services/Providers shall be in accordance with 42 CFR 438.210 s. (c) and s. 438.404.

C. Assuring Services of Qualified Providers

1. Certified Providers – Medicaid. For all Medicaid covered services, the MCO will use certified Medicaid providers as per:

* WI Administrative Code 105 "Provider Certification"
* 42 CFR 422.204 "Provider Selection and Credentialing"
* 42 CFR 438.214(a) Provider Selection
* 42 CFR 438.206(b)(6) Delivery Network
* 42 CFR 438.610(a) and (b) Prohibited Affiliations with Individuals Debarred by Federal Agencies
* 1932(d)(4) Physician Identifier

2. Exceptions: Exceptions may include emergency medical services and non-clinical services or as otherwise requested by the MCO and approved by the Department.

3. For all non-Medicaid State plan services, the MCO will select qualified providers.

4. Provider Selection (Non-Discrimination). The MCO will follow applicable Federal and State laws relating to nondiscrimination as per:

* 42 CFR 422.204 Provider Selection and Credentialing
* 42 CFR 438.12(a)(1) Provider Discrimination
* 42 CFR 438.214(c) Provider Discrimination
* Americans with Disabilities Act of 1990, 42USC s. 1210
* 42 CFR 438.214(d) Provider Selection

5. Practice Guidelines: The MCO will adopt practice guidelines that meet the following requirements:

a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
b. Consider the needs of the enrollees;

c. Are adopted in consultation with contracting health care professionals; and,
d. Are reviewed and updated periodically as appropriate.

* 42 CFR 438.236(b) Practice Guidelines
* HFS 107.035 Definition and Identification of Experimental Services

6. The MCO must disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

* 42 CFR 438.236(d) Dissemination of Guidelines

7. Health Information System: The MCO must ensure that data received from providers is accurate and complete by:

a. Verifying the accuracy and timeliness of reported data;
b. Screening the data for completeness, logic, and consistency; and,
c. Collecting service information in standardized formats to the extent feasible and appropriate.

* 42 CFR 438.242(b)(2) Health Information Systems

8. The MCO will use only CLIA certified laboratories as specified by 42 CFR Part 493D.

9. Access Standards. The MCO will assure that access to covered services will be in accordance with current CMS "Guidelines for Access Standards" attached as Addendum III to this contract.

* 42 CFR 438.206(c)(1)(i), (c)(1)(iv), (c)(1)(v), (c)(1)(vi) Furnishing of Services-Timely Access

D. Assuring the Use of Standard Language

The Department's subcontract review will assure that the MCO has the following standard language in subcontracts (except for specific provisions that are inapplicable in a specific MCO management subcontract).

* 42 CFR 438.230(a), (b)(1), (b)(2), (b)(3), (b)(4) Subcontractual Relationships and Delegation General Rule and Specific conditions

1. General Conditions. The subcontractor agrees to abide by all applicable provisions of the MCO's contract with the Department, hereafter referred to as the MCO contract. Subcontractor compliance with the MCO contract specifically includes but is not limited to the following requirements.

2. Required Provisions. The Subcontract agrees:

    a. Certification. To use only MA-certified providers in accordance with Article V.C., Assuring Services of Qualified Providers.
    b. Liabilities. The terms of this subcontract shall not terminate legal liability of the MCO under the contract with the Department.
    c. QA/QI. To participate and contribute data to the MCO's QA programs as required.
    d. Emergency Services. To provide timely emergency and urgent care. Where applicable, subcontractor agrees to follow required hospital/emergency room procedures for urgent and emergency care cases.
    e. Reporting. To submit utilization data in the format specified by the MCO in order to meet the Department specifications.
    f. Records – Retention. To comply with all record retention requirements.
    g. Records – Access. To provide representatives of the MCO, as well as duly authorized agents or representatives of the Department and CMS, access to its premises and its contract and/or medical records.
    h. Records – Confidentiality. To preserve the full confidentiality of medical records and protect from unauthorized disclosure all information, records, and data collected under the Contract. Access to this information shall be limited to persons who, or agencies which, require the information in order to perform their duties related to this Contract, including CMS and such others as required by the Department.
    i. Records – Maintenance and Transfer. To maintain and transfer medical records as stipulated by the MCO contract and to make medical records available to members and their authorized representatives within a period not to exceed thirty (30) days if the records are maintained on site and sixty (60) days if maintained off site. 45 CFR 164.524(3)(b)(2)
    j. Records – Complaints. To forward to the MCO medical records pursuant to appeals within fifteen (15) working days of the request or, immediately, if the appeal is expedited. If the subcontractor does not meet the fifteen (15) day requirement, the subcontractor must explain reason(s) for the delay and indicate when the subcontractor will deliver the required medical records.
    k. Complaints and Appeals. To inform providers (hospitals, clinics, individual physicians), in the MCO's network about the complaint/appeal procedures and rights of the MCO member.
    l. Access. Not to impose requirements on recipients that are inconsistent with the provision of medically necessary and covered Medicaid and Medicare benefits (e.g., third party liability (TPL) recovery procedures that delay or prevent care) and that create barriers to access to care.
    m. Member Protection. To ensure that all contractual or other written arrangements with providers prohibit the MCO providers from holding any beneficiary member liable for payment of any fees that are the legal obligation of the MCO as per:

* 42 CFR 422.502(q)(l)(i) Contract Provisions between the M+C and CMS
* 1903(m)(L)(A)(ii) of the SSA – Contract Provisions, Beneficiary Financial Protection

n. Non-Discrimination. To comply with all non-discrimination requirements in the MCO contract in accordance with the Americans with Disabilities P.L. 101-336 and Americans with Disabilities Act 1990, 42 USC s. 1210.
o. Referral. To clearly specify referral approval requirements to its providers and in any sub-subcontracts.
p. Billing. Not to bill a Medicaid and Medicare member for medically necessary services covered under the MCO contract. This provision shall continue to be in effect even if the MCO becomes insolvent. However, if an enrollee agrees in writing to pay for a non-MA or non-Medicare covered service, then the MCO, the MCO provider, or the MCO subcontractor can bill the member. Subcontractor also agrees not to bill enrollees for any missed appointments while members are enrolled in WPP.
q. Marketing. To abide by the MCO's marketing/informing requirements. Subcontractor will forward to the MCO for prior approval all flyers, brochures, letters, and pamphlets the subcontractor intends to distribute to its WPP enrollees concerning its managed care affiliation(s), changes in affiliation, or relates directly to the Partnership population. Subcontractor will not distribute any "marketing" or recipient informing materials without the consent of the MCO and the Department.
r. Non-Payment – Appeals. To abide by the terms of the MCO contract regarding appeals for non-payment of services.

E. Insolvency Protection

Under current law, s.1903(m)(l)(A)(ii) of the Social Security Act, members enrolled in the MCO are not liable for the debts of the MCO or its subcontractors in case of the MCO's insolvency.

* 1932(b)(6) Protect Against Liability
* 42 CFR 438.106(a) All 438.106 are Liability for Payment
* 42 CFR 438.106(b)(1) and (b)(2)
* 42 CFR 438.106(c)
* 42 CFR 438.6(1) Contract Requirements
* 42 CFR 438.230 Sub-contractual Relationships and Delegation
* 42 CFR 438.204(a) Elements of State Quality Strategies
* 42 CFR 438.116(a) Solvency Standards

F. Protection of Enrollee-Provider Communications

The Department prohibits interference with physician advice to member. The MCO must not prohibit or otherwise restrict health care professionals from advising beneficiaries about their

health status, medical care, or treatment regardless of whether benefits for such or treatment are provided under the contract.

* 1932(b)(3)(D) Alternative Treatment
* 42 CFR 438.102(a)(i), (a)(ii), (a)(iii), (a)(iv) Provider Enrollee Communications-General Rules

G. Assuring Access to Documents and Records

Access to Medicaid Documents and Records. The MCO agrees to maintain for six (6) years all books, records, subcontracts, documents and other materials relating to all provisions, reimbursements and activities related to this contract. The MCO shall ensure the Department's, CMS, and their duly authorized representatives' right to inspect, evaluate, and audit these materials through six (6) years from the final date of this contract period or completion of audit, whichever is later.

* 42 CFR 438.6(g) Inspection and Audit of Financial Records
* 45 CFR 74.53 Uniform Administrative Requirements…Retention Requirements

H. Assuring Cultural Competency as required by the Partnership Protocol

* 42 CFR 438.206(c)(2) Cultural Considerations

I. Assuring Fair Payment Practices

1. The Department's subcontract review will assure that the MCO has conducted and conducts fair payment practices.

2. Payment to Subcontractors.

    a. The MCO Claim Retrieval System. Maintain a claim retrieval system that, upon request, can identify date of receipt, action taken on all provider claims (i.e., paid, denied, other), and when action was taken.
    b. Thirty (30) Day Payment Requirement. Pay at least ninety (90) percent of adjudicated (clean) claims from subcontractors for covered medically necessary services within thirty (30) days of receipt of clean claim, ninety-nine (99) percent within ninety (90) days, and one hundred (100) percent within one hundred eighty (180) days except to the extent subcontractors have agreed to later payment. The MCO agrees not to delay payment to subcontractors pending subcontractor collection of third party liability (TPL) unless the MCO has an agreement with their subcontractor to collect TPL.

        * 42 CFR 447.46 Timely Claims Payment by MCOs
        * 42 CFR 447.45 (d)(2), (d)(3), (d)(5), (d)(6) Timely Processing of Claims

c. Inappropriate Payment Denials. If the MCO inappropriately fails to provide or deny payments for services, may be subject to suspension of new enrollments, withholding, in full or in part, of capitation payments, contract termination, or refusal to contract in a future time period. This clause applies not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal has been made (i.e., the Department is knowledgeable about the documented abuse from other sources).
d. Payments for Court-Ordered Services. Pay for covered services provided by a non-MCO provider to any participant pursuant to a court order (for treatment), effective with the receipt of a written request for referral from the non-MCO provider, and extending until the MCO issues a written denial of referral. This requirement does not apply if the MCO issues a written denial of referral within seven (7) days of receiving the request for referral.

J. Physician Incentive Plans

1. The Protocol on "Partnership Physician Arrangement – Physician Incentive Plan" details these requirements as per:

* 42 CFR 422.208, 417.479 PIP: Requirements and Limitations
* Stark Laws I & II
* SSA 1903(m)(2)(A)(viii) & SSA1903(m)(4) Disclosure of Ownership and Report Transactions
* 42 CFR 438.6(h) Physician Incentive Plans
* 42 CFR 438.210(e) State Requirements
* 1903(m)(2)(A)(x) Prohibition
* 42 CFR 422.210 Disclosure of PIP
* 42 CFR 438.6(h) PIP Requirements
* 42 CFR 434.70(a)(3) Conditions for FFP (Federal Financial Participation)

2. Requirements. The MCO may operate a Physician Incentive Plan only if no specific payment of any kind is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit covered medically necessary services furnished to individuals enrolled in the MCO. Indirect payments include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

K. Providers' Appeals.

The MCO will conduct fair payment practices.

1. Provider Appeals for Medicaid and Long-Term Care Services

a. All providers must appeal first to the MCO if they disagree with the MCO's payment or non-payment of a claim. The MCO must respond to the appeal within forty-five (45) days.

b. The MCO must inform providers in writing of the MCO's decision to pay or deny the original claims, including:

    i. A specific explanation of the payment amount or specific reason for non-payment.
    ii. A statement regarding the provider's rights to appeal to the MCO.
    iii. The name of the person and/or function at the MCO to whom provider appeals should be submitted.
    iv. An explanation of the process that the provider should follow when appealing the MCO's decision:

        (a) A statement advising providers of their right to appeal to the Department if the MCO fails to respond to the appeal within forty-five (45) days or if the provider is not satisfied with the MCO's response to the request for reconsideration. Appeals to the Department must be submitted in writing within sixty (60) days of the MCO's final decision, or in the case of no response, within sixty (60) days from the forty-five (45) day timeline allotted the MCO to respond.

c. The MCO must accept written appeals from providers within sixty (60) days of the MCO's initial payment and/or nonpayment notice. The MCO must respond in writing within forty-five (45) days from the date of receipt of the request for reconsideration. If the MCO fails to respond within forty-five (45) days, or if the provider is not satisfied with the MCO's response, the provider may seek a final determination from the Department.
d. d. After a provider has appealed to the MCO according to the terms described above, and the provider disputes the determination, the provider may appeal to the Department for the final determination. Appeals must be submitted to the Department within sixty (60) days of the date of written notification of the MCO's final decision resulting from a request for reconsideration, or, if the MCO fails to respond, within sixty (60) days from the forty-five (45) day timeline allotted the MCO to respond. In exceptional cases, the Department may override the MCO's time limit for the submission of claims and appeals. The Department will not exercise its authority in this regard unreasonably. The Department will accept written comments from all parties to the dispute prior to making a final decision. The Department has forty-five (45) days from the date of receipt of all written comments to inform the provider and the MCO of the final decision. If the Department's decision is in favor of the provider, the MCO will pay provider(s) within forty-five (45) days of notification of the Department's final determination. The MCO must accept the Department's determination regarding appeals of disputed claims.

2. Appeals for Medicare services are covered under the Centers for Medicare and Medicaid Services (CMS) Medicare Advantage/Part D contract with the MCO for the Partnership Program.

L. Ineligible Association

Upon obtaining information or receiving information from the Department or from another verifiable source, the MCO shall exclude from participation all organizations which could be included in any of the following categories:

1. Entities Which Could Be Excluded Under s. 1128(b)(8) of the Social Security Act.

2. Entities Which Have a Direct or Indirect Substantial Contractual Relationship with an Individual or Entity Listed which could be excluded under s. 1128(b)(8) of the Social Security Act.

3. Entities Which Employ, Contract With, or Contract Through Any Individual or Entity That is Excluded From Participation in Medicaid under ss. 1128 or 1128A, for the Provision (Directly or Indirectly) of Health Care, Utilization Review, Medical Social Work or Administrative Services.

M. Payments

1. Billing Members – Allowed Practices. If a member agrees in advance in writing to pay for a non-Medicaid and/or non-Medicaid home and community-based waiver services or a non-Medicare covered service, then the MCO, its provider, or its subcontractor can bill the member. A standard release form does not relieve the MCO and its providers and subcontractors from the prohibition against billing a Medicaid member in the absence of a knowing assumption of liability for a non-Medicaid covered service.

2. Billing Members – Disallowed Practices. The MCO and its providers and subcontractors will not bill a member for medically necessary services covered under the contract and provided during the member's period of the MCO enrollment, except as provided for in the post-eligibility treatment of income. Any provider who knowingly and willfully bills a Partnership member for a Medicaid covered service may be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in s. 1128B(d)(1)[42 U.S.C. 1320-7b] of the Social Security Act. This provision shall continue to be in effect even if the MCO becomes insolvent.

    * 42 CFR 438.106(b) and (c) Protect Against Liability- State Non-Payment
    * 42 CFR 438.6(1) Contract Requirements
    * 42 CFR 438.230 Subcontractual Relationships and Delegation
    * 42 CFR 438.204(a) Elements of State Quality Strategies

3. Payments. Be responsible for payment of all contract services provided to all recipients listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Reports generated for the month of coverage. Additionally, the MCO agrees to provide or authorize provision of, services to all Medicaid enrollees with valid Medicaid ID identification cards indicating MCO enrollment without regard to

disputes about enrollment status and without regard to any other identification requirements. Any discrepancies between the cards and the reports will be reported to the Department for resolution. The MCO shall continue to provide and authorize provision of all contract services until the discrepancy is resolved. This includes recipients who were PENDING on the Initial Report and held a valid Medicaid identification card indicating MCO enrollment, but did not appear as an ADD or CONTINUE on the Final Report.

4. Payments to Federally Qualified Health Centers (FQHCs). If the MCO contracts with a facility or program, which has been certified as an FQHC, for the provision of services to its enrollees, the MCO must increase the FQHC's payment in direct proportion to the annual increase the MCO receives from the Department for physicians. In other words, if the MCO receives a ten (10) percent increase from the Department for physicians' services, the contracted rates paid to the FQHC either through capitation or FFS, must be increased by at least ten (10) percent over those that were in effect on the date this contract is signed.

N. Reporting

If the MCO contracts with an FQHC, it must report to the Department within forty-five (45) days of the end of each quarter (for example, January 1 – March 31 is due May 15) the total amount paid to each FQHC, per month as reported on the 1099 forms prepared by the MCO for each FQHC. FQHC payments include direct payments to a medical provider who is employed by the FQHC.

ARTICLE VI

MARKETING AND MEMBER MATERIALS

Contents:

A. Outcome

Marketing information is appropriate and accurate, and does not mislead, confuse or defraud members or consumers.

The outcome is met when all marketing materials are approved by CMS and the Department.

B. Department's Approval of Marketing Materials

The MCO shall submit to Department for prior written approval all marketing materials, including all information regarding the provider network, prepared for Medicaid-only or Medicaid/Medicare recipients. All marketing materials and any changes to marketing materials must be approved by the Department and CMS prior to distribution. All marketing materials shall be distributed to the MCO's entire service area.

1. Review Consideration. The Department will review marketing plans and materials in a manner which does not unduly restrict or inhibit the MCO's marketing strategies.

2. Timeline for Department's Approval. The Department will review marketing plans and materials within forty-five (45) days. Marketing materials must also be approved by the Department and CMS prior to distribution.

3. Necessary Information. The MCO must ensure that a potential member or a member receives accurate oral and written information sufficient to make informed choices.

4. Integrity of Informing. The MCO's marketing materials shall be accurate and not mislead, confuse or defraud recipients or otherwise misrepresent the MCO, its marketing representatives, the Department, or CMS. Statements that would be considered inaccurate, false, or misleading include, but are not limited to any assertion or statement (whether written or oral) that:

a. The recipient must enroll in the MCO in order to obtain benefits or in order to not lose benefits; or,
b. The MCO is endorsed by CMS, the Federal or State government, or other similar entity.

C. Prohibited Practices

The Department prohibits the following marketing practices:

1. Tie-ins with other insurance products;

2. Cold calls, either door-to-door or telephone;

3. Offer of material or financial gain to Medicaid or Medicare recipients as an inducement to enroll; and,

4. Activities that could mislead, confuse or defraud consumers.

D. Evidence of Coverage

1. General Requirement. Provide to MCO members or their legal representatives, within one week of initial enrollment notification, annually thereafter and whenever the enrollee requests, an Evidence of Coverage which is appropriate for, and easily understood by, its target population and has been reviewed and approved using the process established by the MCO's internal advisory body, the Department and CMS. Before a significant change may take effect, the MCO must provide members with written notice at least thirty (30) days prior to the intended change. The Department will have final authority to determine what a significant change is.

2. Required Information. The handbook at a minimum will include information about:

    a. Being a Member of the Partnership Program. This information shall include the nature of Partnership membership as compared to FFS and requirements related to lock-in and prior authorization for services;
    b. Policies on the Use of Emergency and Urgent Care Facilities;
    c. Phone Number;

        i. The toll free phone number that can be used for assistance in obtaining emergency care or for prior authorization for urgent care; and,
        ii. A toll free number where enrollees and potential enrollees can acquire information about the requirements and benefits of the program.

    d. Location of facilities;
    e. Hours of Service;
    f. Information on Contract Services Offered by the MCO;
    g. Members' Rights and Responsibilities;

h. Voluntary Enrollment or “Lock-In”;
i. Complaint Procedures;
j. Appeal Procedures;
k. Expedited Review;
l. Prior Authorization Policy;
m. Second Medical Opinion;
n. Billing Members;
o. Advance Directives;
p. Member Liability for unauthorized services; and,
q. Disenrollment.

E. Handbook Updates and Non-English Versions

1. Handbook Updates. The MCO must provide periodic updates to the handbook, as needed, explaining changes in the above policies. Such changes must be approved by the Department prior to distribution.

2. Non-English Versions. Enrollee handbooks (or substitute enrollee information approved by the Department which explains the MCO services and how to use the MCO) shall be made available in at least the following languages: Spanish, Russian, Lao, and Hmong if the MCO has members who are conversant only in those languages.

   As an alternative to making available the entire Evidence of Coverage in Spanish, Russian, Lao, and Hmong, the MCO may:

   a. Insert a note in the Interpreter Services Section of the Evidence of Coverage. The note shall be written in each of the above languages and will direct the member to a customer service number for assistance in understanding the handbook and in receiving services; or,
   b. Include in the handbook a note that directs the members who are not conversant in English to the appropriate resources within the MCO for obtaining a copy of the handbook with the appropriate language.

3. Standard Language. Standard language for complaint and appeal rights as well as for emergency services and urgent care may be provided by the Department and shall appear in all handbooks.

F. Reading Comprehension and Cultural Sensitivity

Materials for marketing and for health-promotion or wellness information produced by the MCO must be appropriate for its target population and reflect sensitivity to the diverse cultures served. An internal advisory body composed of consumers, experts on readability and health related subjects will establish a process to review and approve the health educational materials produced by the MCO. Also, if the MCO uses material produced by other entities, the MCO must review these materials for appropriateness to its target population and for sensitivity to the diverse

cultures served. Finally, the MCO must make all reasonable efforts to locate and use culturally appropriate health-related materials.

G. Right to Publish

The Department agrees to allow the MCO to write and have such writing published provided the MCO receives prior written approval from the Department before publishing writings on subjects associated with the work under this contract. The MCO agrees to protect the privacy of individual MCO participants, as required under “General Requirements.”

H. Failure to Abide

Any contractor who fails to abide by marketing requirements may be subject to any and all sanctions available under Article XVII, Remedies for Violation. In determining any sanctions, the Department will take into consideration any past unfair marketing practices, the nature of the current problem, and the specific implications on the health and well being of the members. In the event that the MCO’s affiliated provider fails to abide by these requirements, the Department will evaluate whether the MCO should have had knowledge of the marketing issue and the ability to adequately monitor ongoing future marketing activities of the subcontractor(s).

ARTICLE VII

ENROLLMENTS AND DISENROLLMENT SYSTEMS

Contents:

A. Outcome

The MCO's enrollment and disenrollment practices are both legal and fair.

The outcome is met when the MCO:

1. Follows written policies and procedures regarding enrollments and disenrollments which comply with applicable Federal and State laws and legislation; and,

2. Does not discriminate against individuals eligible to enroll on the basis of race, color or national origin and does not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin; and does not discriminate in enrollment and disenrollment activities between individuals on the basis of medical history, current medical condition (except mental illness), required health care services, income, pay status, claims experience, or any other factor not applied equally to all.

B. Applicable Laws and Legislation

The MCO shall comply (to the extent compliance is required in light of the demonstration terms and conditions of October 16, 1998) with all applicable Federal and State laws and legislation relating to the outcome, including:

* 42 CFR 422.110 Discrimination Against Beneficiaries Prohibited
* 42 CFR 438.56 Disenrollment: Requirements and limitations
* 42 C.F.R 438.6 Contract Requirements
* Wis. Stats. 146.81 Health Care Records; Definitions
* 42 CFR 422.50 Eligibility to Elect an M+C Plan
* 42 CFR 422.54 Continuation of Enrollment
* 42 CFR 422.56 Limitations on Enrollment in an M+C MSA Plan
* 42 CFR 422.57 Limited Enrollment Under M+C RFB Plans
* 42 CFR 422.60 Election Process

* 42 CFR 422.62 - Election of Coverage Under an M+C Plan
* 42 CFR 422.64 - Information About the M+C Program
* 42 CFR 422.66 - Coordination of Enrollment and Disenrollment Through M+C Organizations
* 42 CFR 422.68 - Effective Dates of Coverage and Change of Coverage
* 42 CFR 422.74 - Disenrollment by the M+C Organization
* 42 CFR 422.80 - Approval of Marketing Materials and Election Forms
* 42 CFR 431, Subpart F - Safeguarding Information on Applicants and Recipients
* Division of Health Care Financing Policy Memo #3 November 5, 1999 entitled
* Integration of Medicaid and Medicare Benefits in PACE and in Partnership Managed Care Programs"
* Wis. Administrative Code HFS 104.01(6) – Coverage While Out of State

C. General Conditions Regarding Enrollment

1. The MCO shall provide voluntary and continuous open enrollment for anyone who:

    a. Is eligible for Medicaid or under provisions approved by CMS for the Partnership waiver to be determined prior to enrollment and annually thereafter;
    b. Is functionally eligible as determined via the Long-Term Care Functional Screen prior to enrollment and annually thereafter;
    c. Is living in the designated service area;
    d. Has not had one or more transplant surgeries considered experimental by the Wisconsin Medicaid Program; and,
    e. Is within the target group served by the MCO.

2. Enrollment of new members will take place in the following order:

    a. The date that all eligibility criteria were met;
    b. The date that the referral was received if the date of the referral was the same for two or more members who met the eligibility criteria on the same date; and,
    c. The time that the referral was received if the date of the referral was the same for two or more members who met the eligibility criteria on the same date.

3. The MCO has no limits on how many potential members eligible for Partnership may be enrolled in a given period of time. The Department, however, has established target member months of enrollment for the current Wisconsin biennial budget. The Department will inform the MCO of the target member enrollment months as they are established and any adjustments to the targets on a semi-annual basis. The MCO must monitor its utilization of member months and notify the Department immediately when the MCO's actual enrollment experience varies significantly (3% or more) from the target.

4. The Department will regard people who have been in nursing facilities with funding provided by Medicaid (no Medicare) for no less than thirty (30) consecutive days as nursing home long-term care recipients. The MCO will make information on relocations available to the Department upon request.

5. The MCO may consult the Department on difficult cases.

6. Non-Enrollment

   The MCO may request a non-enrollment for any of the following reasons:

   a. Protocol #1. In cases where a member, having been involuntarily disenrolled for willful noncompliance or threatening behavior, desires to re-enroll within twelve (12) calendar months of the effective date of the involuntary disenrollment, the Partnership site may request a non-enrollment due to a history of willful noncompliance or threatening behavior.
   b. Protocol #2. The potential member and/or potential member's family/guardian express the desire for the potential member to remain at home (or, if the potential member is currently in a nursing home or an alternative setting such as a CBRF, to return home) but the team, along with the potential member, the potential member's primary care physician and the MCO's medical director, cannot develop a care plan which complies with WPP practice guidelines and the standards of practice for medicine and nursing in Wisconsin.
   c. Protocol #3. The potential member, at the time of referral, is living in substitute care (substitute care includes but is not limited to Nursing Home, Adult Family Home, or CBRF) with no desire to change residence or cannot with natural supports and the program return to their own or their family home.
   d. Protocol #4. The potential member has a primary diagnosis which is excluded in the capitation rate. This includes, but is not limited to, people with mental retardation (a full scale IQ of 70 or less as ascertained by recent testing); people with major mental illnesses who are currently a risk to themselves or others as documented by the treating psychiatrist; and, people with traumatic head injuries where cognitive and behavioral symptoms are evident.

7. Non-Enrollment Procedures

   a. The Department will review the MCO's request for non-enrollment and either approve or disapprove it in writing within fifteen (15) days.
   b. If the Department disapproves the request for non-enrollment, the MCO shall contact the person and offer enrollment.
   c. Notification to Applicant: If the Department upholds the MCO's denial, the MCO must send written notification to the applicant with the following information:

      i. A statement that the enrollment is denied;

ii. A written notification to applicant explaining the reason for denial; and,
iii. A statement advising the applicant about the rights of the applicant to appeal the denial; and that the applicant may appeal to the MCO, the Department, and/or the Division of Hearings and Appeals.

d. The MCO shall not counsel or otherwise discourage enrollment of a potential enrollee with a confirmed diagnosis of AIDS, as indicated by an ICD-9-CM diagnosis code or who is HIV-Positive if that person is on antiretroviral drug treatment approved by the Federal Drug Administration.

D. Voluntary Disenrollment

The MCO shall not counsel or otherwise encourage voluntary disenrollment of an enrollee with a confirmed diagnosis of AIDS, as indicated by an ICD-9-CM diagnosis code or who is HIV-Positive if that person is on antiretroviral drug treatment approved by the Federal Drug Administration.

Members may voluntarily disenroll without cause at any time.

E. Involuntary Disenrollment

1. Involuntary Disenrollment from Partnership. The MCO may not request disenrollment because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except as specified in items a. through d. below). The Department has approved the following special "Protocols for Disenrollment" from Partnership:

    a. The member has a demonstrated history of ongoing, willful non-compliance with an essential treatment plan that has resulted in significant physical risk to the individual as demonstrated by clinical records, and that risk continues.
    b. The cognitively impaired member's informal support system fails to protect the member from abuse and/or neglect in the home setting, AND, there is significant risk to the person, AND, the family or guardian refuses an alternate living setting.
    c. The program no longer has a contract with the member's physician, AND, the member refuses to change physicians.
    d. The member has committed acts of physical or verbal abuse that pose a threat to the MCO staff, subcontractors or other members of the MCO. This includes but may not be limited to verbally threatening behavior or an exhibition of harassing behavior. A person will not be eligible to re-enroll in the Partnership Program for a minimum of twelve (12) months.

2. Department Approval for Involuntary Disenrollment.

   Involuntary disenrollment from Partnership requires the Department's approval. A proposed involuntary disenrollment shall be subject to timely review and prior authorization by the Department, pursuant to subsection (3), Involuntary Disenrollment Procedure, below. The MCO can request involuntary disenrollment for any of the following reasons:

   a. Absence. When the member is out of the service area for more than thirty (30) consecutive days, unless the MCO agrees to a longer absence due to extenuating circumstances (see 42 CFR 460.164(a)(3)).
   b. Protocol Provisions. When a member's case meets one of the protocols for disenrollment, pursuant to s. (1), Involuntary Disenrollment from Partnership, above.
   c. Contract termination or loss of either HMO Licensure or exemption from HMO Licensure.

3. Involuntary Disenrollment Procedure.

   a. Disenrollment Request. The MCO shall submit to the Department a written request to process all involuntary disenrollments. With each request, the MCO shall submit to the Department evidence attesting to the above situations.
   b. Department's Approval. The Department will notify the MCO about its decision to approve or disapprove the involuntary disenrollment request within fifteen (15) days from the date the Department has received all information needed for a decision. Upon Department approval of the disenrollment request, the MCO must, within three (3) business days, forward copies of a completed Disenrollment Request form to the County Economic Support Worker and to the Medicare enrollment agency (for dual eligibles).
   c. Notification to the Member. When the Department approves the MCO's request, the MCO must send written notification to the member that includes:

      i. A statement that the MCO intends to disenroll the member;
      ii. The reason(s) for the intended disenrollment; and,
      iii. A statement about the member's right to challenge the decision by asking for reconsideration from the Department to disenroll and how to appeal such a decision. (See Partnership protocol on "Complaint and Appeals.")

4. The Department will make all involuntary disenrollment decisions based upon criteria and procedures set forth in this contract and will be effective as described in Addendum I.

5. Disenrollment Appeal. If the member files a written appeal of the disenrollment within ten (10) days of the decision to disenroll (see Article IX.L.), disenrollment shall be delayed until the appeal is resolved.

F. Loss of Waiver Eligibility

1. A member can lose Partnership waiver eligibility for the reasons stated below (a.-d.). The effective disenrollment dates for loss of waiver eligibility are as follows:

    a. Loss of Financial Eligibility. If the member is determined to be financially ineligible, their enrollment will end concurrent with Medicaid eligibility as described in Addendum I.
    b. Loss of Functional Eligibility. If the member is determined to be functionally ineligible, the MCO will notify the appropriate county Economic Support worker within five (5) days. Eligibility will cease as described in Addendum I.
    c. Out of Area Residence. If the member moves permanently out of the catchment area, the date of disenrollment shall be the date when the move occurs. The Department will recoup capitation payment to reflect a mid-month disenrollment and will continue to recoup any whole capitation payments made for months subsequent to the month an out of area move occurs.
    d. Death. If the member dies, the date of disenrollment shall be the date of death. The Department will recoup capitation payment to reflect a mid-month disenrollment and will continue to recoup any whole capitation payments made for months subsequent to the month a member dies.

2. Notification to the Member. When the MCO notifies the County and Medicare enrollment agencies of the loss of waiver eligibility, the MCO shall also send written notification to the member. This written notification shall include:

    a. A statement that the member is no longer eligible for the Partnership program;
    b. The reason(s) for the loss of waiver eligibility; and,
    c. The phone number of the County Economic Support Worker if Medicaid eligibility was established through the County or the Social Security Administration if the person has SSI.

G. Re-Enrollment and Transition Out of the MCO

1. All re-enrollments will be treated as new enrollments except that when a member re-enrolls within two months after losing waiver eligibility, that member's re-enrollment will not be treated as a new enrollment.

2. The MCO shall assist participants whose enrollment ceases for any reason in obtaining necessary transitional care through appropriate referrals, by making medical records available to the participants' new providers; and (if applicable) by working with the Department to reinstate participants' benefits in the FFS system.

ARTICLE VIII

MEMBER RIGHTS

Contents:

A. Outcome

The MCO safeguards its members' rights. The outcome is met when the MCO follows its written policies and procedures in place to designate and protect the rights of its members. Those policies and procedures must include, at a minimum, items C. through D., below.

B. Member Rights and Responsibilities

The MCO shall have in effect written safeguards of the rights of enrolled participants, including a member bill of rights, in accordance with regulations and with other requirements of 42 CFR 438.100, Enrollee Rights and Protections, and of Federal and State laws that are designed for the protection of Partnership members.

C. Advance Directives

The MCO must maintain written policies and procedures regarding advance directives. An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated.

1. Written Information. The MCO shall provide written information at the time of enrollment and periodically thereafter to reflect changes in State laws as soon as possible but within ninety (90) days of any changes regarding:

    a. The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
    b. The MCO's written policies respecting the implementation of such rights; and,
    c. Participant right to complain to the Department of failures by the MCO to comply with advance directives.

2. Documentation. The MCO shall document in the participant's medical records whether or not the participant has executed an advance directive.

3. Fair Treatment. The MCO shall not establish any conditions in the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive.

4. Compliance. The MCO shall ensure compliance with requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives.

5. Education. The MCO shall provide education for the MCO staff and members on issues concerning advance directives.

6. Right to Object. The above provisions shall not be construed to prohibit the application of any Wisconsin law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

D. Provision of Interpreters

Provide interpreter services for members, as necessary, to ensure availability of effective communication regarding treatment, medical history or health education.

1. Access to Interpreters. Furthermore, the MCO must provide for twenty-four (24) hour a day, seven (7) days a week access to interpreters conversant in languages spoken by the population in the MCO's service area including at least Spanish and Hmong. Also, upon a recipient or provider request for interpreter services in a specific situation where care is needed, the MCO shall make all reasonable efforts to acquire an interpreter in time to assist adequately with all necessary care, including urgent and emergency care.

2. Documenting Services. The MCO must routinely document all such efforts. This documentation must be available to the Department at the Department's request.

3. Professional Interpreters. Professional interpreters shall be used when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend as interpreter is inappropriate.

4. Family Members as Interpreters. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical.

5. Active List of Interpreters. The MCO will maintain a current list of interpreters who are "on call" status to provide interpreter services. The list shall include experts in American Sign Language. Provision of interpreter services must be in compliance with Title VI of the Civil Rights Act.

ARTICLE IX

COMPLAINTS AND APPEALS

Contents:

A. Outcome

The MCO has and follows complaint and appeals policies and procedures which comply with applicable State and Federal requirements.

Outcome is met when:

1. The MCO abides by the provision of this article;

2. The MCO has developed and implemented complaint and appeals policies and procedures that comply with applicable State and Federal requirements. These policies and procedures shall be provided to the Department upon request; and,

3. The MCO has submitted quarterly complaints and appeals reports per the requirements in Addendum IV of this contract.

B. Definitions

As used in this article, the following terms have the indicated meanings:

1. An “Action” is:

    a. The denial or limited authorization of a requested service, including the type or level of service;
    b. The reduction, suspension, or termination of a previously authorized service;
    c. The denial, in whole or in part, of payment for a service;

d. The failure to provide services in a timely manner, as defined by the State; or,
e. The failure of the MCO to act within the timeframes provided in 42 CFR 438.408(b).

2. An “appeal” is a request for review of an “action.”

3. A “complaint” is an expression of an enrollee’s dissatisfaction about any matter other than an “action.”

C. General Requirements for Complaints

1. The MCO must have a system in place for enrollees that includes a MCO complaint process that also provides access to the Department’s complaint process.

2. Filing requirements – Authority to file.

   An enrollee or an enrollee’s legal representative or anyone acting on the enrollee’s behalf with the enrollee’s written permission may file a complaint to the MCO or to the Department.

3. Filing requirements – Timing – Those who have authority to file a complaint, as specified above, can file a complaint to the MCO or the Department at any time.

4. Procedures.

   a. An individual with authority may file a complaint either orally or in writing with the MCO and/or in writing-only to the Department. The MCO must attempt to resolve all oral complaints informally.
   b. All complaints, whether they are resolved informally or formally, must be documented by the MCO.
   c. The MCO must follow the complaint procedures discussed in its Evidence of Coverage.

D. General Requirements for Appeals

1. The MCO must have a system in place for enrollees that includes a MCO appeal process that provides access to a Department process and a fair hearings process at the Department of Administration/Division of Hearings and Appeals (DHA).

2. Filing requirements – Authority to file.

   An enrollee or an enrollee’s legal representative or anyone acting on the enrollee’s behalf with the enrollee’s written permission can file an appeal to the MCO, to the Department, and/or to the DHA. A provider may also file an appeal on behalf of an enrollee to the parties listed above.

3. Filing requirements – Timing – Those who have authority to file an appeal, as specified above, must file an appeal to the MCO or the Department or request a fair hearing with the DHA within forty-five (45) days of the MCO's notice of action.

4. Procedures.

    a. An individual with "authority to file" can file an appeal either orally or in writing with the Department and/or the MCO or can request a fair hearing with the DHA, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed appeal.
    b. All appeals must be documented and adjudicated as required in this article.
    c. The MCO must follow the appeal procedures discussed in its Evidence of Coverage.

E. Notice of Action and Appeal Rights

1. The MCO must provide a written notice of action to affected members when the MCO applies or intends on applying an "action" as defined in s. B., above.
2. Language and format requirements. A notice of any "action" provided to an enrollee must be in writing, with oral interpretation available, and must meet the language and format requirements of 42 CFR 438.10(c) and (d) to ensure ease of understanding.

    The notice must explain the following:

    a. The action the MCO or its contractor has taken or intends to take.
    b. The reasons for the action.
    c. The right of the person with authority to file to appeal to the MCO and/or the Department in regard to the "action."
    d. The right of the person with authority to file to request a fair hearing with the DHA simultaneous with, or in any order in regard to, the MCO and Department appeals.
    e. The enrollee's right to request the assistance of the Managed Care Ombuds.
    f. The procedures for exercising the rights specified in this paragraph, including appropriate phone numbers and addresses.
    g. The circumstances under which expedited resolution is available and how to request it.
    h. The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

3. Timing of notice. The MCO must mail the notice (e-mail doesn't meet the contract notification requirements) within the following timeframes:

    a. For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 CFR 431.211, 431.213, and 431.214.

b. For denial of payment, at the time of any action affecting the claim.
c. For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 CFR 438.210(d)(l).
d. For service authorization decisions not reached within the timeframes specified in 42 CFR 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.
e. For expedited service authorization decisions, within the timeframes specified in 42 CFR 438.210(d).

4. If the MCO extends the timeframe to authorize a service or provide notice in accordance with 42 CFR 438.210(d)(l), it must:

    a. Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file an appeal if he or she disagrees with that decision; and,
    b. Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

F. Handling of Complaints and Appeals

General requirements. In handling complaints and appeals, the MCO must meet the following requirements:

1. Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

2. Acknowledge receipt of each complaint and appeal.

3. Ensure that the individuals who make decisions on complaints and appeals are individuals:

    a. Who were not involved in any previous level of review or decision making regarding an "action," and
    b. Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease:

        i. An appeal of an "action" that is based on lack of medical necessity.
        ii. An appeal regarding denial of expedited resolution of an appeal.
        iii. A complaint or appeal that involves clinical issues.

G. Special Requirements for Appeals

The process for appeals must:

1. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the individual with authority to file requests expedited resolution.

2. Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO must inform the enrollee of the limited time available for this in the case of expedited resolution.)

3. Provide the enrollee and his or her representative an opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

4. Provide the following persons a reasonable opportunity to be parties to the appeal:

    a. The enrollee and his or her representative; or,
    b. The legal representative of a deceased enrollee's estate.

H. Basic Rule of Complaints and Appeals

The MCO must dispose of each complaint and resolve each appeal, and provide a final decision, as expeditiously as the enrollee's health condition requires, within State established timeframes that may not exceed the timeframes specified in this article.

I. Timeframes for Complaints and Appeals

1. Standard disposition of a complaint. For standard disposition of a complaint and final decision to the affected parties, the timeframe is ninety (90) days from the day the MCO receives the complaint.

2. Standard resolution of appeals. For standard resolution of an appeal and final decision to affected parties, the timeframe is forty-five (45) days from the day the MCO receives the appeal. This timeframe may be extended as described in s. J.(1) of this article.

3. Expedited resolution of appeals. For expedited resolution of an appeal and notice to affected parties, the timeframe is three (3) calendar days after the MCO receives the appeal. This timeframe may be extended as described in s. J.(2) of this article.

J. Extension of Appeals Timeframes

1. The MCO may extend the timeframes of standard appeals as specified in s. I.(2), above, by up to fourteen (14) calendar days if:

a. The enrollee or the enrollee's representative requests the extension; or,
b. The MCO shows (to the satisfaction of the Department, upon its request) that there is need for additional information and that a delay is in the enrollee's best interest.

2. The MCO may extend the three (3) calendar day timeframe of expedited appeals up to a total of fourteen (14) calendar days if either of the criteria specified above in s. J.(1)(a) and (b) are met.

3. Requirements following extension. If the MCO extends the timeframes, it must, for any extension not requested by the enrollee or the enrollee's representative, give the enrollee and/or representative written notice of the reason for the delay.

K. Resolution of Appeals

1. The MCO will use the following method to notify an enrollee and/or an enrollee's representative of the resolution of an appeal.

    a. The MCO must provide the appeal resolution in writing within forty-five (45) days of the receipt of the appeal.
    b. For an expedited resolution, the MCO must also make reasonable efforts to provide the resolution orally.
    c. Content of appeal resolution. The written resolution must include the following:

        i. The results of the resolution process and the date it was completed.
        ii. For appeals not resolved wholly in favor of the enrollees:

            (a) The right to appeal to the Department and/or to request a fair hearing with the DHA, and how to do so;
            (b) The right to request to receive benefits while the hearing is pending, and how to make the request; and,
            (c) That the enrollee may be held liable for the cost of those benefits if the Department or DHA upholds the MCO's action.

2. Requirements for State fair hearings.

    a. The State must permit the enrollee to request a fair hearing with the DHA within forty-five (45) days from the date of the MCO's notice of action.
    b. The parties to the fair hearing include the MCO, the Department, as well as the enrollee and the individual with authority to file or the representative of a deceased enrollee's estate.

3. Expedited resolution of appeals.

    a. General Rule. The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (in regard to a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.
    b. Punitive Action. The MCO must ensure that punitive action is not taken against the provider or the individual who requests an expedited resolution or supports an enrollee's appeal.
    c. If the MCO denies a request for expedited resolution of an appeal, it must:

        i. Transfer the appeal to the timeframe for standard resolution in accordance with s. I.(2), above; and,
        ii. Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

4. Reversed appeal resolutions.

    a. Services not furnished while the appeal is pending. If the MCO, the Department, or the DHA reverses a decision to deny, limit, or delay services that were not furnished during the appeal, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.
    b. Services furnished while the appeal is pending (See s. L., below). If the MCO, the Department, or the DHA reverses a decision to deny authorization of services, and the enrollee received the disputed services during the appeal, the MCO or the Department must pay for those services in accordance with Department policy and regulations.

L. Continuation of Benefits During Appeals

1. Terminology. As used in this section, "timely" filing means filing on or before the later of the following:

    a. Within ten (10) days of the MCO's mailing the notice of action (e-mail doesn't meet the notification requirements; or,
    b. The intended effective date of the MCO's proposed action.

2. Continuation of benefits. The MCO must continue the enrollee's benefits if:

    a. The enrollee or representative files the appeal timely;
    b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

c. The services were ordered by an authorized provider;
d. The original period covered by the original authorization has not expired; and,
e. The enrollee requests extension of benefits.

3. Duration of continued or reinstated benefits.

   If, at the enrollee's request, the MCO continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

   a. The enrollee or representative withdraws the appeal.
   b. Ten (10) days pass after the MCO mails the resolution of the appeal against the enrollee, unless the enrollee or representative, within the ten (10) day timeframe, has requested:

      i. An appeal with the Department or a State fair hearing with the DHA; and,
      ii. Continuation of benefits until a Department or DHA decision is reached.

   c. The Department or DHA issues a decision adverse to the enrollee.
   d. The time period or service limits of a previously authorized service has been met.

4. Enrollee responsibility for services furnished while the appeal is pending. If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's action, the MCO or its providers may recover the cost of services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR 431.230(b).

M. Record Keeping and Reporting Requirements

1. The MCO must maintain records of complaints and appeals.

2. The MCO must report complaints and appeals to the Department on a quarterly basis per the requirements in Addendum IV of this contract.

ARTICLE X

QUALITY ASSURANCE / QUALITY IMPROVEMENT (QA/QI) AND EXTERNAL REVIEW

Contents:

A. Outcome

Ensure the ongoing quality assessment and performance improvement of services provided to program participants.

1. The outcome is met when the MCO:

    a. Demonstrates that it has an internal quality improvement system described in an annual report to the Department;
    b. Provides documentation that it has reviewed and if appropriate, taken steps for improving the quality of services provided by subcontractors as reported in the annual delegation of authority report to the Department;
    c. Provides documentation that it has reviewed and if appropriate, taken steps for improving, access to health care in an annual report to the Department;
    d. Provides documentation of the results of physician credentialing in an annual report to the Department;
    e. Provides the results of member satisfaction survey indicating overall satisfaction of at least eighty (80) percent in an annual report to the Department;
    f. Achieves demonstrable improvement in significant aspects of clinical and non-clinical care areas that can be expected to have a favorable effect on health outcomes and participant satisfaction, as evidenced in the two annual project reports to the Department; and,
    g. Demonstrates improvement in the support provided to consumers in achieving their desired outcomes. Improvements will be measured using the baselines established in the Member Outcomes Assessment report of July 2001. Target improvement levels are as follows: an improvement of five (5) percentage points in the levels of support achieved in areas where support was present

less than eighty (80) percent of the time. (Where levels of support were seventy-five (75) percent to seventy-nine (79) percent, improvement to the support being present eighty (80) percent of the time will be sufficient to meet this outcome.)

B. QA/QI Regulations

1. General Medicaid Requirements. Comply with Medicaid regulations which require a Quality Improvement system that:

    a. Is consistent with the utilization control requirement of 42 CFR 456, Utilization Control;
    b. Has appropriate health professionals reviewing the provision of health services;
    c. Provides for systematic data collection of performance and patient results;
    d. Provides for interpretation of this data to the practitioners; and,
    e. Provides for making needed changes.

        * 42 CFR 438.242(a) Health Information Systems-collecting, analyzing, integrating & reporting data

C. QA/QI Program

Program. The MCO must have a comprehensive QA/QI program that protects, maintains, and improves the quality of care provided to Medicaid and Medicare program recipients. The MCO must evaluate the overall effectiveness of its QA/QI program annually to determine whether the program has demonstrated improvement, where needed, in the quality of care and service provided to its population. The MCO must describe the QA/QI committee and its activities in an annual report to the Department.

* 42 CFR 438.240(a)(1) QI Program in Place

D. QA/QI Monitoring and Evaluation

1. Guidelines and Quality Indicators. The MCO agrees to submit required data for the Partnership Mini Encounter Database until replaced by encounter data reporting, and the Partnership Intake, Enrollment & Event Database as per Article XII.C.(4). This data will be used to identify areas for external quality review and provide information for further quality improvement. (Encounter data will also be used for purposes of rate setting. See Article XII.) The primary indicator of consideration will be in the area of ambulatory care sensitive conditions (ACSC) and the MCO's ability to manage the care of members with ACSC's in the community.

    * 42 CFR 438.240(a)(2) CMS and State Performance Measures
    * 42 CFR 438.240(b)(1) Health Information Systems-Encounter Data

2. QA/QI Priority Areas. The MCO must also monitor and evaluate care and services in certain priority health and psychosocial areas of interest specified by the Department.

3. QA/QI Studies. The MCO must make documentation available to the Department upon request regarding QA/QI and assessment studies on plan performance which relate to the Medicaid population.

* 42 CFR 438.240(b)(2), and (c): Elements of State Quality Strategy

E. QA/QI Access to Health Care

1. Demonstrate that enrolled recipients have access to screening, diagnosis and referral, and appropriate treatment for those conditions and services covered under Partnership.

2. Written Standards. The MCO must have written standards for the accessibility of care and services, which are communicated to providers and monitored. The standards must include the following:

a. Waiting times for care at facilities;
b. Waiting times for appointments;
c. A statement that providers' hours of operation do not discriminate against Medicaid enrollees; and,
d. A statement specifying whether or not providers speak members' languages.

F. QA/QI Provider Selection and Evaluation

1. Written Policies. The MCO must have written policies and procedures for provider selection and qualifications.

2. The MCO must periodically monitor (no less than every three years) the physician's documented qualifications to assure that the physician still meets the MCO's specific professional requirements.

3. The MCO's professional accreditation requirements may not exclude culturally diverse behavioral health providers or subcontractors.

4. Notification to Department. In addition to the requirements in this section, the MCO must immediately forward to the Department the names of physicians who have been terminated from the MCO physician network as a result of quality issues.

G. QA/QI Members' Feedback

1. Communication Processes. The MCO must have a process(s) to maintain a relationship with its members that promotes two-way communication and contributes

to quality of care and services. The MCO shall demonstrate a commitment to treat members with respect and dignity and to involve members in QA/QI initiatives.

2. Member Feedback. Some methods to receive member feedback include: focus groups, consumer advisory councils, member participation on the governing board, the QA/QI committee or other committees; or task forces related to evaluating services. Documentation of efforts to solicit feedback from Partnership members must be available to the Department upon request.

H. QA/QI Utilization Management (UM)

Documented Policies. The MCO must have documented policies and procedures for utilization review that reflect current standards of medical practice in processing requests for initial or continued authorization of services. The MCO must also have in effect mechanisms to detect both under-utilization and over-utilization of services.

* 42 CFR 438.240(b)(3) Over and Under Utilization of Services

I. QA/QI External Quality Review

External Quality Review Organization (EQRO) for Medicaid and Medicare. The MCO must assist the Department and the external quality review organization under contract with the Department in identifying and collecting information required to carry out on-site or off-site medical chart reviews, interviews with care teams and members. The EQRO will review care management practices surrounding the care and treatment of ACSCs. The EQRO will also be reviewing records to validate data submitted to the Department. Finally, the EQRO will be reviewing data collected by the Department and its contractors to assess the MCO's compliance with Medicaid regulations and this contract.

* 42 CFR 438.204(e)(2) Program Review

J. Annual QA/QI Studies and Indicators

1. Annual Survey. Annually, the MCO shall internally survey a representative sample of its enrolled members to identify their level of satisfaction with the MCO's services. The survey's purpose is to identify potential problems and barriers to care. The MCO shall have a system in place for acting on survey results.

2. Two Annual Performance Improvement Projects. The MCO may select two areas of study from the lists for Annual Performance Improvement Projects that the Department has recommended for the Partnership program. The MCO may select studies not on these lists; however study topics not on the recommended lists are subject to Department approval.

3. Cooperation with CMS and the Department. The MCO shall cooperate with CMS and the Department to conduct studies and surveys as part of the demonstration program evaluation.

4. Semiannual Progress Reports. The MCO will report to the Department on its progress twice per year. Reports shall be in writing and my include:

    a. Accomplishments;
    b. Utilization Management;
    c. Staff Development;
    d. Marketing;
    e. Special Studies Conducted, if any;
    f. Barriers and Solutions; and,
    g. Plans for Next Quarter.

        * 42 CFR 438.240(b)(1), (d)(1) Performance Improvement Projects
        * 42 CFR 438.240(d)(2) Performance Improvement Projects – Timeline for Completion

ARTICLE XI

HUMAN RESOURCES

Contents:

A. Outcome

The MCO uses qualified staff and does not discriminate in staffing and in service delivery.

1. Outcome is met when the MCO:

    a. Complies with the applicable laws and legislation in s. B. of this article and the references listed therein; and,
    b. Demonstrates compliance through submission of the following reports and/or updates to the Department per the Reporting Requirements in Addendum IV:

        i. Civil Rights Compliance Plan with Workforce Analysis.

2. These plans are considered approved by the Department's Affirmative Action/Civil Rights Compliance (AA/CRC) Office, unless the AA/CRC Office informs the MCO otherwise.

B. Applicable Laws and Legislation

1. The MCO shall comply with all applicable Federal and State laws and legislation relating to the outcome including:

    * § 16.765, Wis. Stats. – Nondiscriminatory Contracts
    * Federal Civil Rights Act of 1964 and regulations issued pursuant to that Act and the provisions of Federal Executive Order 11246 dated September 26, 1985
    * Section 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794)
    * 45 CFR Part 84 and all guidelines and interpretations issued pursuant thereto
    * Age Discrimination and Employment Act of 1967
    * Age Discrimination Act of 1975
    * Caregiver Law of 1998
    * See Addendum VII, Compliance Agreement, Affirmative Action/Civil Rights, for other pertinent legislation

ARTICLE XII

INFORMATION ACCESS AND SECURITY

Contents:

A. Outcome

The MCO maintains and has safeguards in place regarding use of, access to, and protection from unauthorized disclosure of all protected health information as defined in 45 CFR 164.501.

Outcome is met when the MCO:

1. Complies with ss. B. and C. of this article and the references therein.

B. Applicable Laws and Legislation

The MCO shall comply with all applicable Federal and State laws relating to the outcome including:

1. Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations issued pursuant to that Act, including:

    * 45 CFR Part 142
    * 45 CFR Parts 160 through 164
    * Balanced Budget Amendment of 1997, s. 438.324, “Confidentiality”
    * 42 CFR 431 Subpart F, “Safeguarding Information on Applicants and Recipients”
    * HFS 104.01(3), Wis. Admin. Code; - Confidentiality of Medical Information
    * HFS 105.02(1)-(7), Wis. Admin. Code; - Requirements for Maintaining Certification
    * HFS 106.02(9)(b), “Medical and Financial Recordkeeping,” Wis. Adm. Code
    * HFS 107.32(1)(d), “Case Management Services,” Wis. Admin. Code
    * HFS 108.01, “Safeguarded Information,” Wis. Admin. Code

C. Other Specific Requirements

1. The MCO agrees to forward to the Department all media contacts regarding Medicaid enrollees for the Medicaid program.

2. The MCO shall use its best efforts to assist enrollees and their authorized representatives in obtaining complete records within ten (10) working days of the record request.

3. Records Access

    a. Records Retention. The MCO shall retain, preserve and make available upon request all records relating to the performance of its obligations under this contract, including claim forms, for not less than six (6) years following the end of this contract period. Records involving matters which are the subject of an audit or litigation shall be retained for a period of not less than six (6) years following the termination of the audit or litigation. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of the Department, provided that the microfilming procedures are approved by the Department as reliable and are supported by an effective retrieval system. Upon expiration of the six (6) year retention period, the subject records shall, upon request, be transferred to the Department's possession. No records shall be destroyed or otherwise disposed of without the prior written consent of the Department.
    b. General Access Requirements. The MCO shall allow the Department and CMS, or their duly authorized agents or representatives, during normal business hours, access to the MCO's premises or the MCO subcontractor's premises to inspect, audit, monitor or otherwise evaluate the performance of the MCO's or subcontractor's contractual activities and shall forthwith produce all records requested as part of such review or audit. Such access shall be maintained through six (6) years from the final date of this contract period or completion of any audit, whichever is later. Access will also include the right to reproduce all such records and material and to verify reports furnished in compliance with the provisions of the Contract.
    c. Financial Records. The MCO and any subcontractors shall make available to the Department, the Department's authorized agents, and appropriate representatives of the U.S. DHHS any financial records of the MCO or subcontractors which relate to the MCO's capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this contract.
    d. Requests for Access. In the event right of access is requested under this article, the MCO or subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the duly authorized State or Federal representatives conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner that will not unduly interfere with the performance of the MCO's or subcontractor's activities.
    e. Findings. The MCO will be given fifteen (15) business days to respond to any findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

4. Encounter Data

    a. General

        i. The MCO shall meet all of the reporting requirements as specified in this contract in a timely way, assure, to the best of their knowledge and beliefs, the accuracy and completeness of the data, and submit the reports/data in a timely manner.
        ii. Data submitted to the Department shall be supported by records available for inspection or audit by the Department.
        iii. The MCO must be able to submit data and/or reports to the Department, or receive data and/or reports from the Department in a secure format.
        iv. The MCO shall designate a contact person responsible for the computer/data reporting who is available to answer questions from the Department and resolve any issues regarding reporting requirements.
        v. A designated person must certify, to the best of their knowledge and beliefs, the accuracy of the data each time the data is transmitted via the Data Certification Form, in which is provided by the Department per 42 CFR 438.600.

    b. Units of Provided Services

        i. The Partnership Organization may report units of provided services (See definition in Article I) either by reporting actual time or by reporting a reasonable estimate of the number of units provided. The data must be validated using the Data Certification Form regardless of whether the Partnership Organization reports actual or estimated units of services.
        ii. If the Partnership Organization reports an estimated number of units of provided services, then the Partnership Organization must use a predictive model that has been prior approved by the Department. The criteria the Department uses to approve the predictive model shall include but not be limited to (a) the Department must have access to a full explanation of the model; (b) the Department must have access to all records and data used by model; and, (c) the predictive model must generate a valid estimate of the number of units of provided services.

    c. Rates for Provided Services

        i. When setting the rates for provided services, the Partnership Organization may include any expenses reasonably associated with the provision of a service to a member.

ii. Costs associated with the following items are not reasonably associated with the provision of a service to a member, but should be reported to the Department as the cost of administration:

(a) Information Technology other than that used by care Managers;
(b) Accounting;
(c) Human Resources;
(d) Marketing;
(e) Quality Assurance/Compliance;
(f) Claims Processing;
(g) Intake Services;
(h) Legal;
(i) Financial Audits; and,
(j) Actuarial Services.

iii. Costs associated with lobbying are not reasonably associated with the provision of a service to a member, and also may not be reported to the Department as the cost of administration.
iv. Costs associated with the Partnership Organization's reinsurance premiums may be reported on a cost-per-member-per-month basis. Payment of claims made by the Partnership Organization's reinsurance company will be treated as a third party payment toward a member specific claim.
v. The Partnership Organization shall submit all rates for provided services to the Department by April 1, 2006 for approval. Rates for provided services may be revised by the Partnership Organization at any time during the duration of this contract with the prior approval of the Department.

d. The Partnership Organization shall ensure that data received from providers, as well as data generated as a result of services provided by the Partnership Organization, and reported to the Department, is timely, accurate and complete, by:

i. Verifying the accuracy and timeliness of reported data;
ii. Screening the data for completeness, logic, and consistency;
iii. Recording and tracking all services with a unique member identification number (the Medicaid ID number); and,
iv. Collecting information on services in standardized formats that are HIPAA compliant to the extent possible or as appropriate for purchased services. (See definition in Article I.)

e. Beginning on a date as specified in subparagraphs i. and ii. below, the Partnership Organization shall report member-specific data to the Department in an encounter-data format specified by the Department. Prior to the

implementation of reporting in the encounter data format, the Partnership Organization shall meet certification standards that demonstrate it has the MIS capacity to meet the Department reporting requirements in the formats and timelines prescribed by the Department. The Partnership Organization will provide data extracts, as necessary, for testing the reporting processes, and will assist with and participate in the testing processes.

i. On or before April 1, 2006, the Partnership Organization shall submit, on a monthly basis, encounter data for all purchased services with dates of service on or after January 1, 2006. (The submitted encounter data will contain both Medicare and Medicaid claims.)
ii. On or before August 15, 2006, the Partnership Organization shall submit, on a monthly basis, encounter data for all provided services with dates of service on or after July 1, 2006.

f. The Encounter Reporting Submission is a monthly report. The Partnership Organization shall report the encounter data that the Partnership Organization has in its possession on the fifteenth (15th) of each month. The Encounter Data Reporting Submission will be used to report member specific enrollment and disenrollment, utilization of services and expenditure in the Partnership benefit package, and member characteristic/demographics. Other client specific data may be required by the Department in the future. The Encounter Reporting Submission shall be reported on-line or through a batch methodology approved by the Department.

g. Analysis of Purchased Services Encounter Data

i. The Partnership Organization recognizes that, for analysis purposes, the Department will attempt to separate Medicare claims from Medicaid claims.
ii. The Department intends to accomplish this goal by looking at a sample of fee-for-service claims to determine the average crossover claim that comes to Medicaid for particular procedures.
iii. The Department will then regard the average crossover claim for the appropriate procedure as the Medicaid portion of each purchased service claim for dual eligibles.
iv. If it is not a Medicare covered service, the Department will regard the full cost as a Medicaid claim.
v. In the case of nursing home claims, the Partnership Organization will notify the Department quarterly of member nursing home admissions and if they qualify as Medicare stays. This submission should indicate the member’s name and MAID, the nursing home admission date and date of discharge if applicable. The Department will calculate the Medicaid participation in the claim.
vi. In the case of dual eligibles, premiums paid for stop loss insurance will be regarded as a Medicare expense.

h. Analysis of Provided Services Encounter Data

i. The Partnership Organization recognizes that, for analysis purposes, the Department must separate Medicare claims from Medicaid claims.

ARTICLE XIII

PAYMENT TO THE MANAGED CARE ORGANIZATION

Contents:

A. Outcome

The Department shall ensure that the MCO receives defined prospective capitation payments for each enrolled member and, where specified, receive adjusted capitation payment or reimbursement for expenses exceeding capitation rates.

B. Medicaid Capitation Rates

In full consideration of contract outcomes delivered by the MCO, the Department agrees to pay the MCO monthly payments based on the capitation rate specified in Addendum VI, Actuarial Basis.

1. Methodology. The capitation rate shall be prospectively designed to be less than the cost of providing the same services covered under this contract to a comparable Medicaid population on a FFS basis. The capitation rate is calculated on an actuarial basis recognizing the payment limits set forth in 42 CFR 438.6(c).

C. Special Capitation for Intensive Skilled Nursing Level (ISN) of Care

1. ISN Capitation Payments. When LTC Functional Screen, or other means approved by the Department, determines that members are at an ISN level of care, the MCO will receive monthly capitation payments for each member qualified for ISN: Provisional Phase-In. If there is an initial period when the capitation rate cannot be delivered on a monthly basis, the MCO will submit a report, within sixty (60) days at the end of the contract, on the total number of ISN enrollment days, the Medicaid ID number of ISN qualified members, and other relevant data as specified by the Department. The Department will conduct a year-end payment adjustment for persons who have been determined to be at the ISN level of care during the contract year. Payments will be made based on the data submitted by the MCO and on the Department's eligibility data.

2. Department's Authority. The Wisconsin LTC Functional Screen, or other means approved by the Department, will be used to determine when a member's health status qualifies to receive Intensive Skilled Nursing level of care. The MCO may conduct a LTC-Functional Screen at any time to determine if a member is at an ISN level of care.

3. Date of Initial Determination and ISN Capitation Payment. A member becomes eligible for the ISN capitation rate when it is determined through the LTC Functional Screen, or other means approved by the Department, that the member qualifies for ISN level of care and that information is provided to the county Economic Support Worker.

4. Termination. When it is determined that a member no longer qualifies for ISN level of care, the Department will terminate the member's ISN capitation payments and reactivate the appropriate capitation rate. The Department will conduct a year-end payment adjustment for those members whose ISN levels of care have changed.

5. Reporting ISN Cases. The MCO shall submit additional reports on the following ISN activities to the Bureau of Long-Term Support - Managed Care Section according to the schedule indicated in Addendum IV, Reporting Requirements, of the contract.

    a. Reporting Changes in ISN Cases. The MCO shall inform the county Economic Support Worker and the Bureau of Long-Term Support - Managed Care Section when a member no longer meets the ISN level of care. The Department will suspend the member's ISN capitation payment and reactivate the capitation rate due to MCO participants. The Department may apply sanctions for the MCO's willful failure to re-determine the level of care of ISN members or to inform the Department about the re-determination.

D. Renegotiation

The monthly capitation rates set forth in this article shall not be subject to renegotiation during the contract term or retroactively after the contract term, unless such renegotiation is required by changes in Federal or State law.

E. Payment Schedule

Payment to the MCO shall be based on the MCO Enrollment Reports which the Department will transmit to the MCO. The Department will issue payments for each person listed as an ADD or CONTINUE in the MCO Enrollment Reports within sixty (60) days of the date the report is generated. The MCO shall accept payments under this contract as payment in full and shall not bill, charge, collect or receive any other form of payment from the Department and the participant except as permitted by Medicaid regulations and agreements with the Department concerning 1115 waivers and post eligibility treatment of income.

F. Coordination of Benefits

1. The MCO shall actively pursue, collect and retain any monies from third party payers for services to enrollees covered under this contract except where the amount of reimbursement the MCO can reasonably expect to receive is less than the estimated cost of recovery (this exemption does not apply to Third Party Liability (TPL) collections for AIDS and ventilator dependent patients), or except as provided in Addendum II, Policy Guidelines on Community-Based Programs.

2. Cost effectiveness of recovery is determined by, but not limited to time, effort, and capital outlay required to perform the activity. The MCO must be able to specify the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party, or describe the process by which the MCO determines seeking reimbursement would not be cost effective, upon request of the Department.

3. To assure compliance, records shall be maintained by the MCO of all COB collections and reports shall be made quarterly on the form designated by the Department in Addendum V, COB Report Format. The MCO must be able to demonstrate that appropriate collection efforts and appropriate recovery actions were pursued. The Department has the right to review all billing histories and other data related to COB activities for enrollees. The MCO must seek from all enrollees, information on other available resources. Other available resources may include, but are not limited to, group or individual health insurance, ERISAs, service benefit plans, and subrogation/workers compensation collections.

   Subrogation collections are any recoverable amounts arising out of settlement of personal injury, medical malpractice, product liability, or Worker's Compensation. State subrogation rights have been extended to the MCO under s. 49.89(9), Wis. Stats. After attorneys' fees and expenses have been paid, the MCO shall collect the full amount paid on behalf of the enrollee.

   The MCO must also seek to coordinate benefits before claiming reimbursement from the Department for the AIDS and ventilator dependent enrollees.

4. Section 1912(b) of the Social Security Act must be construed in a beneficiary-specific manner. The purpose of the distribution provision is to permit the beneficiary to retain TPL benefits to which he or she is entitled to except to the extent that Medicaid (or the MCO on behalf of Medicaid) is reimbursed for its costs. The MCO is free, within the constraints of State law and this contract, to make whatever case it can to recover the costs it incurred on behalf of its enrollee. It can use the Medicaid fee schedule, an estimate of what a capitated physician would charge on a FFS basis, the value of the care provided in the market place or some other acceptable proxy as the basis of recovery. However, any excess recovery, over and above the cost of care (however the MCO chooses to define that cost), must be returned to the beneficiary. The MCO is to follow the practices outlined in the Department's Casualty Recovery Manual.

5. Personal Injury Settlements. When the MCO is aware of personal injury case settlements, the MCO will submit any information regarding such settlement to the Department as soon as practical. The MCO may use the form attached as Addendum VIII, Personal Injury Settlements, for reporting these settlements.

6. COB collections are the responsibility of the MCO or its subcontractors. Subcontractors must report COB information to the MCO. The MCO and subcontractors shall not pursue collection from the enrollee, but directly from the third party payer. Access to medical services will not be restricted due to COB collection.

7. The following requirement shall apply if the MCO (or the MCO's parent firm and/or any subdivision or subsidiary of either the MCO's parent firm or of the MCO) is a health care insurer (including, but not limited to, a group health insurer and/or health maintenance organization) licensed by the Wisconsin Office of the Commissioner of Insurance and/or a third-party administrator for a group or individual health insurer(s), health maintenance organizations(s), and/or employer self-insurer health plan(s):

    a. Throughout the Contract term, these insurers and third-party administrators shall comply in full with the provision of s. 49.475 of the Wisconsin Statutes. Such compliance shall include the routine provision of information to the Department in a manner and electronic format prescribed by the Department and based on a monthly schedule established by the Department. The type of information provided shall be consistent with the Department's written specifications.
    b. Throughout the Contract term, these insurers and third-party administrators shall also accept and properly process post-payment billings from the Department's fiscal agent for health care services and items received by Wisconsin Medicaid enrollees.

G. Recoupments

The Department will not normally recoup the MCO per capita payments when the MCO actually provided service or due to subsequent ineligibility determination. However, the Department may recoup the MCO capitation payments in the following situations:

1. Change in Participant's Status.

    a. The Department will recoup the MCO's capitation payments for the following situations when a member's eligibility status has changed before the first day of a month for which a capitation payment has been made:

        i. The member moves out of the MCO's service area;
        ii. The member enters a public institution; or,

iii. The member dies.

b. The Department will recoup the MCO's capitation payments for the following situations when the Department initiates a change in a member's status on a retroactive basis, reflecting the fact that the MCO was not able to provide services. In these situations, recoupments for multiple-month capitation payments are more likely:

i. Correction of a computer or human error, where the person was never really enrolled in the MCO; and,
ii. Disenrollments of members.

2. Disputed Membership. When membership is disputed between two contractors, the Department shall be the final arbitrator of membership and reserves the right to recoup an inappropriate capitation payment.

3. Contract Termination. If a contract is terminated, recoupments will be handled through a payment by the MCO within thirty (30) days of contract termination.

H. Adjustments

The Department will make a retrospective payment adjustment whenever:

1. The actual enrollment months by age does not match the projected enrollment by age cohort used for setting SNF/ICF and ISN rates.

2. The actual nursing home level of care distribution does not match the projected nursing home level of care distribution used for setting SNF/ICF rates.

3. The actual average HCC score of the MCO's enrollment does not match the projected average HCC score used for setting rates.

4. If actuarially sound, the actual functional status of Partnership enrollment does not match the projected functional status of Home and Community-Based Waiver recipients used for setting SNF/ICF rates.

5. The proportion of enrollees who are dually eligible for both Medicare and Medicaid coverage does not match the projected distribution of Medicare and/or Medicaid eligible for setting SNF/ICF and ISN rates.

6. Payments for the adjustments will take place within the first quarter of the year after receipt of the certified cost report required by Article XIV.B.(8), Annual Report.

I. Payment for Aids, HIV-Positive, and Ventilator Dependent

The Department will pay the MCO's costs of providing Medicaid-covered services provided to MCO enrollees who meet the criteria in this section. These payments will be made based on the date submitted by the MCO to the Department on a quarterly basis using the format specified in Addendum XI, AIDS/Ventilator Dependent Report Format. The data submission schedule is included in Addendum IV, Reporting Requirements, of this contract. Reimbursement already provided to the MCO for Medicaid costs in the form of capitation payments for qualified enrollees will be deducted from one hundred (100) percent reimbursement payments for Medicaid costs. The MCO will retain $41.86 per non-institutionalized day for long-term care services and will remain responsible for those services. The criteria for qualified enrollees are:

1. Ventilator Assisted Patients. Costs incurred for enrollees who need ventilator treatment services qualify for reimbursement if the enrollee meets the following criteria:

    a. Criteria. For the purposes of this reimbursement, a ventilator-assisted patient must have died while on total respiratory support or must meet all of the criteria below:

        i. The patient must require equipment that provides total respiratory support. This equipment may be a volume ventilator, a negative pressure ventilator, a continuous positive airway pressure (CPAP) system, or a Bi (inspiratory and expiratory) PAP. The patient may need a combination of these systems. Any equipment used only for the treatment of sleep apnea does not qualify as total respiratory support.
        ii. The total respiratory support must be required for a total of six or more hours per twenty-four (24) hours.
        iii. The patient must have total respiratory support for at least thirty (30) days which need not be continuous.
        iv. The patient must have absolute need for the respiratory support as documented by appropriate blood gases.

    b. Documentation. The MCO will submit the following written documentation to qualify enrollees for reimbursement at the same time as the quarterly report identified in Addendum XI, AIDS/Ventilator Dependent Report Format.

        i. A signed statement from the doctor attesting to the need of the patient.
        ii. Copies of progress notes which show the need for continuation of total ventilatory support, any change in the type of ventilatory support, and the removal of the ventilatory support.
        iii. Copies of lab reports must be submitted if the progress notes do not include blood gas levels.

    c. The following methodology will be used to determine months that qualify for enhanced funding:

i. The first qualifying day is the day that the patient is placed on the ventilator. If the patient is on the ventilator for less than six hours on the first day, the use must continue into the next day and be more than six total hours.
ii. Each day that the patient is on the ventilator for a part of any day, as long as it is part of the six total hours per twenty-four (24) hours, counts as a day for enhanced funding.
iii. The period qualifying for enhanced funding starts on the first day of the month that the patient was placed on ventilator support. It ends on the last day of the month after which the patient is removed from the ventilatory support, or at the end of the hospital stay, whichever is later.

2. AIDS or HIV-Positive with Anti Retroviral Drug Treatment. Costs for services provided to enrollees with a confirmed diagnosis of AIDS, as indicated by an ICD9-CM diagnosis code or who are HIV-Positive, qualify for reimbursement if the enrollees are on Anti Retroviral Drug treatment approved by the Federal Drug Administration. Written requests to qualify enrollees for reimbursement must be submitted by the MCO to the Department's fiscal agent. These requests should be batched and submitted with the report identified in Addendum XI, AIDS/Ventilator Dependent Report Format. A signed statement from a physician that indicates a diagnosis of AIDS or HIV-Positive and that the patient is on an Anti Retroviral Drug treatment must accompany each request. One hundred percent reimbursement of Medicaid costs will be effective for services provided on or after the first day of the month in which treatment begins.

   For AIDS and HIV-Positive members retroactively disenrolled under Article VII, Enrollment and Disenrollment Systems, of the contract, the MCO will have to back out of the care provided during the backdated period from the report in Addendum XI, AIDS/Ventilator Dependent Report Format.

3. Submission of Data for Ventilator Assistance and AIDS Treatment. As required by Wisconsin law, payment data or adjustment data for enrollees under paragraph 1. or 2., above, must be received by the Department's fiscal agent within 365 days after the date of the service. If the MCO cannot meet this requirement, the MCO must provide good cause documentation that substantiates the delay. The Department will make the final determination to waive the three hundred sixty-five (365) day billing requirement.

ARTICLE XIV

FISCAL PROVISIONS – RISK RESERVE

Contents:

A. Outcome

Ensure continuity of care for enrolled members through sound financial management and the deposit of risk reserves necessary to sustain care in the event of insolvency or operating deficits. The MCO is responsible for providing care through the period for which capitated payment has been made, as well as for inpatient admissions up until discharge.

The outcome is met when the MCO demonstrates that they retain reasonable operating reserves and the minimum risk reserves as required by the Wisconsin Office of the Commissioner of Insurance (OCI). The Department may, at it discretion, require copies of any and all reports or correspondence related to HMO licensure.

B. Quarterly Financial Reports

The following reports and calculations must be submitted within forty-five (45) days of the close of each quarter. The submissions of these reports and calculations may be required on a more frequent basis at the discretion of the Department.

1. Budgeted versus Actual Financial Report, for current and year-to-date periods;

2. A simplified balance sheet;

3. A calculation of the current ratio, (Current Assets + Risk Reserve/Current Liabilities);

4. A calculation of days cash on hand, (Cash + Marketable Securities))/((Operating Expenses – Depreciation)/365);

5. A calculation of the total debt to net worth ratio, (Current + Long-Term Debt)/Net Worth; and,

6. Risk Reserve investment summaries on a third party letterhead.

C. Audit Results

The MCO agrees to provide the results of an audit, for the prior calendar year, by July 1, which includes:

1. Results of the annual audit, including “Letters to Management” and any supplemental financial statements, which are part of the annual audit performed by an independent certified public accountant; and,

2. A clear indication of total costs, direct and indirect, related to enrollees, or estimates of total costs that are based on generally accepted accounting principles.

3. The MCO shall authorize the independent accountant to allow representatives of the Department, upon written request, to verify the audit report and any supporting work papers and documentation. Supplemental financial statements shall be presented in a form specified by the Department that clearly shows the financial position of the MCO in Partnership. These supplemental financial statements may be prepared by the MCO.

ARTICLE XV

FUNCTIONS AND DUTIES OF THE DEPARTMENT

Contents:

A. Outcome

The MCO receives timely information and assistance from the Department.

The outcome is met when enrollment reports, feedback on other reports specified within this contract, marketing materials and requests for non-enrollments and requests for involuntary disenrollments are acted on as specified in this contract.

B. Enrollment

Promptly notify the MCO of all Medicaid recipients enrolled in the MCO under this contract. Notification shall be effected through the MCO Enrollment reports. All recipients listed as an ADD or CONTINUE on either the Initial or Final MCO Enrollment Reports are members of the MCO during the enrollment month. The reports shall be generated in the sequence specified under the MCO Enrollment Reports.

C. Disenrollment

Promptly notify the MCO of all Medicaid recipients no longer eligible to receive services through the MCO under this contract. Notification shall be effected through the MCO Enrollment Reports which the Department will transmit to the MCO for each month of coverage throughout the term of the contract. The reports shall be generated in the sequence under the MCO Enrollment Reports. Any recipient who was enrolled in the MCO in the previous month, but does not appear as an ADD or CONTINUE on either the Initial or Final MCO Enrollment Report for the current enrollment month, is disenrolled from the MCO effective the last day of the previous enrollment month.

D. Enrollment Reports

For each month of coverage throughout the term of the contract, the Department shall transmit "MCO Enrollment Reports" to the MCO. These reports will provide the MCO with ongoing information about its Medicaid enrollees and disenrollees and will be used as the basis for the monthly capitation claims described in Article XIII, Payment to the Manager Care Organization. The MCO Enrollment Reports will be generated in the following sequence:

1. The Initial MCO Enrollment Report will list all of the MCO's enrollees and disenrollees for the enrollment month that are known on the date of report generation. The Initial MCO Enrollment Report will be received by the MCO on or before the fifth day of each month covered by the contract. A capitation claim will be generated for each enrollee listed as an ADD or CONTINUE on this report. Enrollees who appear as PENDING on the Initial Report and are reinstated into the MCO during the month will appear as a CONTINUE on the Final Report and a capitation will be generated at that time.

2. The Final MCO Enrollment Report will list all of the MCO's enrollees for the enrollment month who are not included in the Initial MCO Enrollment Report. The Final MCO Enrollment Report will be received by the MCO on or before the tenth day of each month subsequent to the coverage month. A capitation claim will be generated for each enrollee listed as an ADD or CONTINUE on this report. Enrollees in PENDING status will not be included on the Final Report.

E. Utilization Review and Control

Waive, to the extent allowed by law, any present Department requirements for prior authorization, second opinions, co-payment, or other Medicaid restrictions for the provision of contract services provided by the MCO to enrollees, except as may be provided in Addendum II, Policy Guidelines on Community-Based Programs.

F. Cooperation with CMS

The Department shall cooperate with the Center for Medicare/Medicaid Services in reporting, monitoring, and submitting documentation pertinent to the MCO's contractual services and performance.

G. Managed Care Organization Review

Submit to the MCO for prior approval materials that describe the MCO and that will be distributed by the Department or County to recipients.

H. Review of Study or Audit Results

1. Release to Public. Submit to the MCO any studies or audits that are going to be released to the public that are about the MCO and Medicaid. The Department will specify a review/comment period of no less than fifteen (15) business days.

2. Department-Initiated Plan of Correction. Under normal circumstances, the Department will not implement a plan of correction prior to the MCO's review and response to a preliminary report. The Department may do so, however, if the circumstances warrant immediate action (i.e., if delays may jeopardize or threaten the health, safety, welfare, rights or other interest of participants).

I. Provider Informing

The Department shall continue to inform providers about Medicaid managed care initiatives, including the Partnership program and their contractors.

J. Provider Certification

The Department shall give the MCO access to the names and contract information for all MA certified providers in the catchment area; in the alternative, the Department shall continue to give the MCO timely responses to the MCO's requests for confirmation of particular providers' MA certification status.

ARTICLE XVI

REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE OF CONTRACT

Contents:

A. Outcome

The Department and the MCO have procedures and criteria in place to remedy contract violations or non-performance.

The outcome is met when the Department and the MCO agree to the specifications of this article as evidenced by their signatures on this contract.

B. Medicaid Program – Termination

Either the MCO or the Department may terminate this contract pursuant to Article XVII.

In lieu of termination, the Department may also impose "Temporary Management" under the same conditions and timeframes as apply for termination of the contract. All notice periods that apply to termination for non-performance and the corresponding obligations of both the MCO and the Department in this article and Article XVII of the contract also apply to the imposition of temporary management.

C. Medicaid Program – Suspension of New Enrollment

Whenever the Department determines that the MCO is out of compliance with this contract, the Department may suspend the MCO's right to enroll new participants under this contract. The Department, when exercising this option, must notify the MCO in writing of its intent to suspend new enrollment at least thirty (30) days prior to the beginning of the suspension period.

The suspension will take effect if the non-compliance remains uncorrected at the end of this period. The Department may suspend new enrollment sooner than the time period specified in this paragraph if the Department finds that participant's health or welfare is jeopardized. The suspension period may be for any length of time specified by the Department, or may be indefinite. The suspension period may extend up to the expiration of the contract.

D. Medicaid Program – Transition

In the case of a participant whose enrollment ceases for any reason, the MCO provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

E. Medicaid Program – Withholding of Capitation Payments and Recovery of Damage Costs

Notwithstanding the provisions of Article XIII, Payment to the MCO, the Department may withhold portions of capitation payments or otherwise recover damages from the MCO on the following grounds:

1. Failure to Provide Covered Services. Whenever the Department determines that the MCO has failed to provide or arrange for one or more of the medically necessary Medicaid covered contract services required under Article IV, Service Coverage, the Department may either order the MCO to provide such service, or recover capitation payments to the MCO, for a member(s), less service costs incurred by the MCO specific to the member(s), or withhold a portion of the MCO's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services. The MCO shall be given at least a seven (7) day prior written notice prior regarding either (1) the Department's ordering the MCO to pay, or (2) the Department's withholding any capitation payments. In case of an emergency, no such seven (7) day notice is required.

   Whenever the Department withholds payments under this section, the Department must submit to the MCO a list of the participants for whom payments are being withheld, the nature of the service(s) denied, and payments the Department must make to provide medically necessary services.

2. Failure to Perform. Whenever the Department determines that the MCO has failed to perform an administrative function required under this contract, the Department may withhold a portion of future capitation payments to compensate for the damages which this failure has entailed. For the purposes of this section, "administrative function" is defined as any contract obligation other than the actual provision of contract services.

3. Recovery of Damages. In any case under this contract where the Department has the authority to withhold capitation payments, the Department also has the authority to use all other legal processes for the recovery of damages.

4. Procedures. In any case where the Department intends to withhold capitation payments under s. (1) above, or recover damages through the exercise of other legal processes under ss. (2) or (3) above, the following procedures shall be used:

a. The Department will notify the MCO of its failure to perform a required administrative function under this contract;
b. The Department shall give the MCO thirty (30) days prior notice to develop an acceptable plan for correcting this failure; and,
c. If the MCO has not submitted an acceptable corrective action plan within thirty (30) days, or has not implemented this plan in accordance with its terms, the Department will provide the MCO with a statement itemizing the damage costs for which it intends to require compensation. The Department shall then proceed to recover said compensation.

F. Medicaid Program – Department-Initiated Disenrollment

The Department may reduce the maximum enrollment level and/or number of current enrollees whenever it determines that the MCO has failed to provide one or more of the contract services required under Article IV, Service Coverage, or that the MCO has failed to maintain or make available any records or reports required under this contract which the Department needs to determine whether the MCO is providing contract services as required under Article IV, Service Coverage. The MCO shall be given at least thirty (30) days notice prior to the Department taking any action set forth in this paragraph.

G. Medicaid Program – Sanctions

Section 1903(m)(5)(B)(ii) of the Social Security Act vests the Secretary of the DHHS with the authority to deny Medicaid payments to the MCO for enrollees who enroll after the date on which the MCO has been found to have committed one of the violations identified in the Federal law. State payments for enrollees of the contracting organization are automatically denied whenever, and for so long as, Federal payment for such enrollees has been denied as a result of the commission of such violations.

H. Medicaid Program – Sanctions and Remedial Actions

The Department may pursue all sanctions and remedial actions with the MCO that are taken with Medicaid FFS providers, including any civil penalties not to exceed the amounts specified in the Balanced Budget Amendment of 1997, s. 4707(a).

ARTICLE XVII

TERMINATION AND MODIFICATION OF CONTRACT

Contents:

A. Outcome

The Department and the MCO clearly convey the conditions and procedures for contract termination and/or modification.

This outcome is met when the Department and the MCO agree to the specifications of this article as evidenced by their signatures on this contract.

B. Medicaid Program – Mutual Consent

This contract may be terminated at any time by mutual consent of both the MCO and the Department.

C. Medicaid Program – Unilateral Termination

This contract may be terminated only as follows:

1. Legislative Changes. In the provision of services under this agreement, the MCO and its subcontractors shall comply with all applicable Federal and State statutes and regulations, and all amendments thereto, that are in effect when the agreement is signed, or that come into effect during the term of the agreement. This includes, but is not limited to Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations. This contract may be terminated at any time, by either party, due to modifications mandated in Federal or State law, regulations, or policies that materially affect either party's rights or responsibilities under this contract. In such case, the party initiating such termination procedures must notify the other party, at least ninety (90) days prior to the proposed date of termination, of its intent to terminate this contract. Termination by the Department under these circumstances shall impose an obligation upon the Department to pay the MCO's reasonable and necessarily incurred termination expenses.

2. Failure to Perform. Failure to comply and/or perform is a reason for contract termination:

a. Either party may terminate this contract at any time if it determines that the other party has substantially failed to perform any of its functions or duties under this contract. In such event, the party exercising this option must notify the other party, in writing, of this intent to terminate this contract and give the other party thirty (30) days to correct the identified violation, breach or non-performance of contract. If such violation, breach or non-performance of contract is not satisfactorily addressed within this time period, the exercising party may terminate this contract. The termination date shall always be the last day of a month. The contract may be terminated by the Department sooner than the time period specified in this paragraph if the Department finds that the participant's or participants', health or welfare is jeopardized by continued enrollment in the MCO. A "substantial failure to perform" means any violation of any contractual requirement that is repeated or on-going, that goes to the essentials or purpose of this contract, or that injures, jeopardizes or threatens the health, safety, welfare, rights or other interests of recipients.
b. In lieu of termination, the Department may also impose "Temporary Management" (See Article XVI).

3. Permanent Loss of Funding. This contract may be terminated by either party, in the event that Federal or State funding of contractual services becomes permanently unavailable. In the event it becomes evident that State or Federal funding of claims payments or contractual services rendered by the MCO will be temporarily suspended or unavailable, the Department shall immediately notify the MCO, in writing, identifying the basis for the anticipated unavailability or suspension of funding. Upon such notice, the Department or the MCO may suspend performance of any or all of the MCO's obligations under this contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. The Department or the MCO shall attempt to give notice of suspension of performance of any or all of the MCO's obligations by sixty (60) calendar days prior to said suspension, if this is possible; otherwise, such notice of suspension should be made as soon as possible.

4. Temporary Loss of Funding. In the event funding is reinstated, the MCO may remove suspension hereunder by written notice to the Department, within thirty (30) calendar days from the date of reinstatement of funds. In the event the MCO elects not to reinstate services, the MCO shall give the Department written notice of its reasons for such decision, to be made within thirty (30) calendar days from the date the funds are reinstated. The MCO shall make such decision in good faith and will provide to the Department documentation supporting this decision. In the event of termination under this section, this contract shall terminate without termination costs to either party.

D. Medicaid Program – Obligations of Contracting Parties

When termination of the contract occurs, the following obligations shall be met by the parties:

1. Where this contract is terminated unilaterally by the Department, due to non-performance by the MCO or by mutual consent with termination initiated by the MCO:

    a. The Department shall be responsible for notifying all enrollees of the date of termination and process by which the enrollees will continue to receive contract services; and,
    b. The MCO shall be responsible for all expenses related to said notification.

2. Where this contract is terminated on any basis not given in (1) above:

    a. The Department shall be responsible for notifying all enrollees on the date of termination and process by which the enrollees will continue to receive contract services; and,
    b. The Department shall be responsible for all expenses relating to said notification.

3. Where this contract is terminated for any reason:

    a. Any payments advanced to the MCO for coverage of enrollees for periods after the date of termination shall be promptly returned to the Department; and,
    b. The MCO shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.
    c. If a contract is terminated, recoupments will be handled through a payment by the MCO within ninety (90) days of contract termination.

4. Where this contract is terminated for any reason, the MCO shall assist participants in their transition to FFS.

E. Medicaid Program – Modification

This contract may be modified at any time by written mutual consent of the MCO and the Department or when modifications are mandated by changes in Federal or State laws, rules or regulations. In the event that changes in State or Federal law, rules or regulations require the Department to modify its contract with the MCO, notice shall be made to the MCO in writing. However, the capitation rate to the MCO can be modified only as provided in Article XIII, Payment to the MCO, relating to RENEGOTIATION.

Enrollment limits may be modified at any time by written mutual consent of the MCO and the Department. The Department may, by written mutual consent with the MCO and other interested parties, redistribute available enrollment months to facilitate continuity of services for program members.

If the Department offers to renew this contract, as allowed by Article XIII, Payments to the MCO, the Department will recalculate the capitation rate for succeeding calendar years. The

Department and the MCO will then have thirty (30) days to negotiate the new capitation rate in writing or to initiate termination of the contract.

ARTICLE XVIII

INTERPRETATION OF CONTRACT LANGUAGE

Contents:

A. Outcome

The Department will provide clear interpretation of contract language and provide an avenue for appeal of interpretations.

B. Interpretations and Appeals

The Department has the right to interpret the contract language when disputes arise. The MCO has the right to appeal to the Department or to invoke the procedures outlined in Chapter 788, Arbitration or Chapter 227 Wis. Stats., if it disagrees with the Department's interpretation. Until a decision is reached, the MCO shall abide by the interpretation of the Department.

C. Documents Constituting Contract

The contractual agreement between the parties to this contract shall include, in addition to this document, existing Medicaid Provider Bulletins addressed to managed care organizations (MCOs). In the event of any conflict in provisions among these documents, the terms of this contract shall prevail. In addition, the contract shall incorporate the following Addenda:

1. Protocol for Partnership

2. Adverse Action Dates

3. Policy Guidelines on Community – Based Programs

4. CMS Guidelines for Access Standards

5. Reporting Requirements

6. COB Report Format

7. Actuarial Basis

8. Compliance Agreement: Affirmative Action/Civil Rights

9. Personal Injury Settlements

10. Payment Schedule

11. Performance Improvement Project Outline

12. AIDS/Ventilator Dependent Report Format

D. Future Documents

This contract requires the MCO to comply with all future Medicaid Provider Publications addressed to the MCOs and Partnership Contract Interpretation Bulletins and Policy Memos issued pursuant to this contract.

The documents listed above constitute the entire contract between the parties and no other expression, whether oral or written, constitutes any part of this contract.

E. Indemnification

1. The MCO agrees to defend, indemnify and hold the Department harmless, with respect to any and all claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of:

    a. Any failure, inability, or refusal of the MCO or any of its subcontractors to provide contract services;
    b. The negligent provision of contract services by the MCO or any of its subcontractors; or,
    c. Any failure, inability or refusal of the MCO to pay any of its subcontractors for contract services.

2. The Department agrees to be responsible to the MCO (and its officers, directors, employees, agents, and subcontractors), for any and all liability, loss, damage, cost, or expense which arises out of any negligent act or omission of the Department or any of its officers, agents or employees while acting within the scope of their employment, where protection is afforded by s. 893.82 and 895.46(1) of the Wisconsin Statutes.

F. Independent Capacity of Contractor

The Department and the MCO agree that the MCO and any agents or employees of the MCO, in the performance of this contract, shall act in an independent capacity, and not as officers or employees of the Department.

G. Omissions

In the event that either party hereto discovers any material omission in the provisions of this contract which such party believes is essential to the successful performance of this contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this contract.

H. Choice of Law

This contract shall be governed by and construed in accordance with the laws of the State of Wisconsin. The MCO shall be required to bring all legal proceedings against Department in Wisconsin State courts.

I. Waiver

No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

J. Severability – Medicaid

If any provision of this contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to Medicaid enrollees and if the remainder of this contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

K. Force Majeure

Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

L. Headings

The article and section headings used herein are for reference and convenience only and shall not entire into the interpretation hereof.

M. Assignability

Except as allowed under subcontracting, the contract is not assignable by the MCO either in whole or in part, without the prior written consent of the Department.

N. Survival

The terms and conditions contained in this contract that by their sense and context are intended to survive the performance by the parties shall so survive the completion of the performance, expiration or termination of the contract.

ARTICLE XIX

CONTRACT FOR MEDICAID SERVICES

PARTNERSHIP HEATLH PLAN SPECIFIC CONTRACT TERMS

1. COUNTIES WHERE ENROLLMENT IS ACCEPTED:

Dunn, Chippewa and Eau Claire Counties

2. MAXIMUM ENROLLMENT LEVEL:

There is no census maximum under this contract.

The Department does not guarantee any minimum enrollment level.

3. CAPITATION RATE:

This is the monthly capitation rate for each non-ISN enrollee:

Elderly – Mississippi County	$ 2,865.11
Disabled - Mississippi County	$ 3,134.87

4. ISN CAPITATION RATE:

This is the monthly capitation rate for ISN qualified members:

Elderly - Mississippi County	$ 3,939.44
Disabled - Mississippi County	$ 5,628.39

5. COVERAGE OF DENTAL: YES

THIS CONTRACT SHALL BECOME EFFECTIVE ON January 1, 2006, AND SHALL TERMINATE ON DECEMBER 31, 2006

In WITNESS WHEREOF, the State of Wisconsin and Partnership Plan, Inc. have executed this agreement:

Partnership Plan	**Department of Health and Family Services**
	Sinikka Santala
Title Chief Executive Officer Partnership Plan, Inc.	Title Administrator Division of Disability and Elder Services
Date	Date

ADDENDUM I

ADVERSE ACTION DATES

The Adverse Action dates for 2006 are:

2006-01-17
2006-02-16
2006-03-16
2006-04-17
2006-05-18
2006-06-16
2006-07-18
2006-08-17
2006-09-15
2006-10-17
2006-11-16
2006-12-18
2007-01-18

ADDENDUM II

POLICY GUIDELINES ON COMMUNITY-BASED PROGRAMS

The MCO shall develop a working relationship with community agencies which are involved in the provision of non-medical services to enrollees. The MCO may under certain conditions be exempted from taking on or continuing to service Medicaid MCO members who require highly specialized or extensive treatment and/or non-medical services for mental illness, methadone treatment, developmental disabilities, or due to elder abuse or domestic violence. The extent of the MCO responsibility for working cooperatively with other community agencies, for treating the medical aspects of the above conditions as legitimate health care problems and the terms under which enrollee exemption may be obtained are specified as follows:

A. Mental Health/AODA Assessment Requirements

The MCO shall further assure that authorization for MH/AODA treatment to its enrollees shall be governed by the findings of an assessment performed promptly by the MCO upon request of a client or referral from a physician. Such assessments shall be conducted by qualified staff in certified programs, who are experienced in MH/AODA. All denials of service and the selection of particular modalities of service shall be governed by the findings of this assessment and the medical necessity of treatment. The lack of motivation of a member to participate in treatment shall not be considered a factor in determining medical necessity and may not be used as a rationale for withholding or limiting treatment of a member.

The MCO shall involve and engage the member in the process used to select a provider and treatment option. The purpose of the participation is to get a good match between the member's condition, cultural preference (See Article V, Provider Network), medical needs and the provider who will seek to meet these needs. This section does not require the MCO to use providers who are not qualified to treat the individual enrollee or who are not contracted providers.

B. Assurance of Expertise for Elder Abuse, Abuse of Vulnerable Adults, and Domestic Violence

The MCO shall arrange for the provision of examination and treatment services by providers with expertise and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of elder abuse, abuse of vulnerable adults, and domestic violence. Such expertise shall include the identification of possible and potential victims of elder abuse and domestic violence, statutory reporting requirements, and local community resources for the prevention and treatment of elder abuse and domestic violence. The MCO shall consult with human service agencies on appropriate providers in their community.

The MCO shall further assure that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision.

C. Court-Related AODA Services

Necessary MCO referrals or treatment authorized for court-related AODA services must be furnished promptly. It is expected that no more than five (5) days will elapse between receipt of a written request by the MCO and the issuance of a referral or authorization for treatment. Such referral or authorization, once determined to be medically necessary, will be retroactive to the date of the request. After the fifth day an assumption will exist that an authorization has been made until such time as the MCO responds in writing.

D. Dispute Resolution

The Department shall be the sole arbitrator of disputes and all requirements of this addendum.

1. Request for Department's Review. A local board, county social or human service department, recipient, or advocate for a recipient, may request a review of complaints regarding denial of access to medically necessary MA-covered services after they have utilized the MCO dispute resolution process. The Department shall review the complaint and make a final determination. The Department will accept written comments from all parties to the dispute prior to making a decision. Failure to promptly (within forty-five (45) days) pay providers for properly referred care will be considered as a denial of access to such care.

2. Department's Ruling. Where a Departmental ruling is invoked in any dispute relating to the terms of this addendum, the Department's decision shall be communicated to the MCO and all other appropriate individuals or organizations in writing and within thirty (30) days of receipt of the request. The MCO shall abide by all decisions of the Department.

ADDENDUM III

CMS GUIDELINES FOR ACCESS STANDARDS

CMS has issued the following Access Standards.

A. Policy

Contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of all covered services on an emergency basis, twenty-four (24) hour–a-day, and seven-day-a-week basis. The Department is invited to propose specific access measures designed for frail elderly and for beneficiaries with physical disabilities, however, at a minimum, shall include:

B. Procedures

1. Time/Distance.

    a. Time/Distance to Primary Care and Hospitals. The Department shall demonstrate that provider networks are in place which guarantee all clients in urban or suburban locations access to primary care sites and hospitals within thirty (30) minutes or twenty (20) miles of their residence. Transport time and distance in rural areas to primary care sites and hospital may be greater than thirty (30) minutes or twenty (20) miles if based on the community standard for accessing care. Where greater, the exceptions must be justified and documented on the basis of community standards. This information must be made available for review upon CMS's request.
    b. Time/Distance to Specialty Care Locations. Travel time/distances to all types of specialty care, including mental health, pharmacy, general optometry, lab and x-ray services, and long-term care services shall not exceed thirty (30) minutes or thirty (30) miles from the member's residence. The Department may exempt individuals who request to receive services from a specialty provider with whom they have an established relationship but the travel time or distance is greater than thirty (30) minutes or thirty (30) miles.

2. Appointment Times. Partnership organizations shall employ sufficient medical personnel and staff to be able to meet basic standards in the scheduling of appointments for their participants or members. Appointments must be available for eligible recipients in accordance with the usual and customary practice standards and hours of operation. Maximum expected waiting times shall be as follows:

    a. Emergency Care. Emergency care must be provided as the situation dictates. In general, emergency care must be given in accordance to the time frame dictated by the nature of the emergency, at the nearest available facility, twenty-four hours a day, seven days a week, regardless of contracts.

b. Urgent Care. Triage and appropriate treatment shall be provided on the same or next day.
c. Non-Urgent Problems and Routine Primary Care. Appointments for non-urgent care and routine primary care shall be provided within three weeks of client request.
d. Specialty Care. Referral appointments to specialists, except for specialists providing mental health and substance abuse services (e.g., specialty physician services, hospice care, home health care, and certain rehabilitation services, etc.) shall not exceed thirty (30) days for routine care or forty eight (48) hours for urgent care. All emergency care must be provided on an immediate basis, at the nearest facility available, regardless of contracting arrangements.
e. General Optometry Services. Partnership organizations must have a system in place to document compliance with the following appointment scheduling time frames. The Department shall monitor compliance with appointment/waiting time standards as part of the required surveys and monitoring requirements.
f. Transport Time. Transport time will be the usual and customary, not to exceed one hour, except in areas where community access standards and documentation will apply.
g. Appointment/Waiting Times. Usual and customary not to exceed thirty (30) days for regular appointments and forty-eight (48) hours for urgent care. (Note: "Usual and customary" means access that is equal to or greater than the currently existing practice in the FFS system.)
h. Pharmacy Services. Partnership organizations must have a system in place to document compliance with the following appointment scheduling time frames. The Department shall monitor compliance with appointment/waiting time standards as part of the required surveys and monitoring requirements.
i. Lab and X-Ray Services. Partnership organizations must have a system in place to document compliance with the following appointment scheduling time frames. The Department shall monitor compliance with appointment/waiting time standards as part of the required surveys and monitoring requirements.

3. In-Office Waiting Times. Partnership members with an appointment shall not routinely be made to wait longer than one hour.

4. Patient Load. The Department shall determine the ratio of Partnership members to primary care physicians. (CMS project officer shall approve patient load ratio, thirty (30) days prior to implementation of the program.

5. Documentation/Tracking Requirements.

   a. Documentation. Partnership organizations must have a system in place to document appointment scheduling times. Wisconsin must utilize statistically valid sampling methods for monitoring compliance with appointment/waiting time

standards as part of the required beneficiary survey and reported to the Department on an annual basis.

b. Tracking. Partnership organizations must have a system in place to document the exchange of client information with the primary care provider if a school-based health center, not serving as the primary care provider, provides health care.

6. Corrective Action Plan. CMS requires the Department to have a corrective action plan for Partnership organizations that score less than 70 percent (or below the benchmarks established by the Department) in beneficiary satisfaction. The Department will monitor the plan.

ADDENDUM IV

STATE REPORTING REQUIREMENTS FOR 2006

Due Date	Type of Report	Reporting Period	Send Report to…	Report Format	Reporting Frequency	Contract Reference(s)
Before contract signing	Affidavit: Standard Language in Subcontracts		BLTS-MCS	Hardcopy	Required Annually	Art V.B.(2)(a) Protocol, pg. 18
Within 15 days contract signing	Civil Rights Compliance Plan with Work Force Analysis.	Contract Period	AA/CR	Hardcopy	Required Triannually	Art XI.A.(1) Add VII.C.(1)
Within 30 days of contract signing	Disclosure of Interest	Prior Twelve Months	BLTS-MCS	Hardcopy	Required Annually	Art III.C.(2)
YEAR 2006						
FIRST QUARTER						
January 31	QA/QI Plan for 2006	Contract Period	BLTS-MCS	Hardcopy	Required Annually	Art X.A.(1)(a) Art X.C.
January 31	2005 Annual Performance Improvement Projects	Contract Period	BLTS-MCS	Hardcopy	Required Annually	Art X.J.(2) Add X.
January 31	ISN Cases	July 1, 2005 through Dec. 31, 2005	BLTS-MCS	Hardcopy	Required Semiannually	Art XIII.C.(5)
February 1	Intake, Enrollment and Event Data File	Jan. 1, 2005 through Dec. 31, 2005	EDS	Electronic Media (including email)	Required Semiannually	Art. X.D.(1) Utilization Reporting User Manual pg. 7
February 1	Complaints and Appeals Summary Report	Oct 1, 2005 through Dec 31, 2005	BLTS-MCS	Email or Hardcopy	Required Quarterly	Art IX.A.(3) and M.
February 1	AIDS/ Ventilator Dependent Report	Reportable Costs as of Present Time	EDS - Olin	Hardcopy and Diskette	Ad-Hoc Quarterly	Art XIII.I. Add XI.
February 15	Provider Network Listing and Physician Credentialing Review	As of Present Time	BLTS-MCS	Hardcopy	Required Annually	Art. V.B.(1)(b) Art X.A.(1)(d) Art X.F.(2)
February 15	Semiannual Progress Report	Jul 1, 2005 through Dec 31, 2005	BLTS-MCS	Hardcopy	Required Semiannually	Art X.J.(5)
February 15	Financial Report	Oct 1, 2005 through Dec 31, 2005	BLTS-MCS	Hardcopy	Required Quarterly	Art XIV.B.(7) Protocol, pg. 150
February 15	Coordination of Benefits Report	Oct 1, 2005 through Dec 31, 2005	BLTS-MCS	Hardcopy	Required Quarterly	Art XIII.F.(3) Add V.
February 15	Federally Qualified Health Centers Report	Oct 1, 2005 through Dec 31, 2005	BLTS-MCS	Hardcopy	Ad-Hoc Quarterly	Art V.N.
SECOND QUARTER						
May 1	Complaints and Appeals Summary Report	Jan 1, 2006 through Mar 31, 2006	BLTS-MCS	Email or Hardcopy	Required Quarterly	see above
May 1	AIDS/ Ventilator Dependent Report	Reportable Costs as of Present Time	EDS - Olin	Hardcopy and Diskette	Ad-Hoc Quarterly	see above
May 15	Financial Report	Jan 1, 2006 through Mar 31, 2006	BLTS-MCS	Hardcopy	Required Quarterly	see above

Due Date	Type of Report	Reporting Period	Send Report to…	Report Format	Reporting Frequency	Contract Reference(s)
May 15	Coordination of Benefits Report	Jan 1,2006 through Mar 31, 2006	BLTS-MCS	Hardcopy	Required Quarterly	see above
May 15	Federally Qualified Health Centers Report	Jan 1, 2006 through Mar 31, 2006	BLTS-MCS	Hardcopy	Ad-Hoc Quarterly	see above
June 30	OCI Report	Jan 1, 2005 through Dec 31, 2005	BLTS-MCS	Hardcopy	Annual	Art. III.B.
THIRD QUARTER						
July 1	Annual Fiscal Audit	Jan 1, 2005 through Dec 31, 2005	BLTS-MCS	Hardcopy	Required Annually	Art XIV.B.(9) Protocol pg. 151
July 30	ISN Cases	Jan 1, 2006 through June 30, 2006	BLTS-MCS	Hardcopy	Required Semiannually	Art XIII.C.(5)
August 1	Complaints and Appeals Summary Report	Apr 1, 2006 through Jun 30, 2006	BLTS-MCS	Email or Hardcopy	Required Quarterly	see above
August 11	Intake, Enrollment and Event Data File	Jan. 1, 2006 through June 30, 2006	EDS	Electronic Media (including email)	Required Semiannually	see above
August 1	AIDS/ Ventilator Dependent Report	Reportable Costs as of Present Time	EDS - Olin	Hardcopy and Diskette	Ad-Hoc Quarterly	see above
August 15	Semiannual Narrative Report	Jan 1, 2006 through Jun 30, 2006	BLTS-MCS	Hardcopy	Required Semiannually	see above
August 15	Financial Report	Apr 1, 2006 through Jun 30, 2006	BLTS-MCS	Hardcopy	Required Quarterly	see above
August 15	Coordination of Benefits Report	Apr 1, 2006 through Jun 30, 2006	BLTS-MCS	Hardcopy	Required Quarterly	see above
August 15	Federally Qualified Health Centers Report	Apr 1, 2006 through Jun 30, 2006	BLTS-MCS	Hardcopy	Ad-Hoc Quarterly	see above
FOURTH QUARTER						
November 1	Complaints and Appeals Summary Report	Jul 1, 2006 through Sept 30, 2006	BLTS-MCS	Email or Hardcopy	Required Quarterly	see above
November 1	AIDS/ Ventilator Dependent Report	Reportable Costs as of Present Time	EDS - Olin	Hardcopy and Diskette	Ad-Hoc Quarterly	see above
November 15	Financial Report	Jul 1, 2006 through Sept 30, 2006	BLTS-MCS	Hardcopy	Required Quarterly	see above
November 15	Coordination of Benefits Report	Jul 1, 2006 Through Sept 30, 2006	BLTS-MCS	Hardcopy	Required Quarterly	see above
November 15	Federally Qualified Health Centers Report	Jul 1, 2006 through Sept 30, 2006	BLTS-MCS	Hardcopy	Ad-Hoc Quarterly	see above
December 1	Delegation of Authority	Contract Period	BLTS-MCS	Hardcopy	Required Annually	Art II.A.(1)(c)(1) Art X.A.(1)(b)
December 1	Satisfaction Survey	Contract Period	BLTS-MCS	Hardcopy	Required Annually	Art X.J.(1) Add III.B.(5)(a)

Due Date	Type of Report	Reporting Period	Send Report to…	Report Format	Reporting Frequency	Contract Reference(s)
YEAR 2006						
FIRST QUARTER						
January 31	ISN Cases	July 1, 2006 through Dec 31, 2006	BLTS-MCS	Hardcopy	Required Semiannually	see above
January 31	QA/QI Plan for 2005	Contract Period	BLTS-MCS	Hardcopy	Required Annually	see above
January 31	2005 Annual Performance Improvement Projects	Contract Period	BLTS-MCS	Hardcopy	Required Annually	see above
February 1	Complaints and Appeals Summary Report	Oct 1, 2006 through Dec 31, 2006	BLTS-MCS	Email or Hardcopy	Required Quarterly	see above
February 1	Intake, Enrollment and Event Data File	Jan. 1, 2006 through Dec 31, 2006	EDS	Electronic Media (including email)	Required Semiannually	see above
February 1	AIDS/ Ventilator Dependent Report	Reportable Costs as of Present Time	EDS - Olin	Hardcopy and Diskette	Ad-Hoc Quarterly	see above
February 15	Provider Network Listing	As of Present Time	BLTS-MCS	Hardcopy	Required Annually	see above
February 15	Semiannual Narrative Report	Jul 1, 2006 through Dec 31, 2006	BLTS-MCS	Hardcopy	Required Semiannually	see above
February 15	Financial Report	Oct 1, 2006 through Dec 31, 2006	BLTS-MCS	Hardcopy	Required Quarterly	see above
February 15	Coordination of Benefits Report	Oct 1, 2006 through Dec 31, 2006	BLTS-MCS	Hardcopy	Required Quarterly	see above
February 15	Federally Qualified Health Centers Report	Oct 1, 2006 through Dec 31, 2006	BLTS-MCS	Hardcopy	Ad-Hoc Quarterly	see above

Reports with No Due Date

Due Date	Type of Report	Contract Reference(s)
As requested by the Department	Subcontracts – template versus individuals	Article V.B.(1)
When applicable	Business Transactions – party-in-interest disclosure	Article III.C.(3)
When applicable	List of physicians terminated because of quality issues	Article X.F.(4)
When applicable	Personal injury settlements	Article XIII.F.(5) Addendum VIII.
When actual enrollment varies significantly from the Department's target	Target member month variations	Article VII.C.(3)
45 days after risk reserve disbursement	Risk reserve disbursement and replenishment plan Note: depository organization will submit annual reports to the Department on status of risk reserve account	Article XIV.B.(6)
When applicable	If the MCO implements physician incentive plan, provide CMS and the Department info to determine whether plan is in compliance	Protocol, pg. 36
When applicable	Abortions & hysterectomies/sterilizations	Article IV.C.(1)
Upon request	HMO licensure reports and/or correspondence	Article XIV.B.(1)
45 days before planned distribution	Participant Handbook	Article VI.E.(1) Protocol, pg. 42

45 days before planned distribution	Marketing materials	Article VI.B. Protocol, pg. 37
Available upon request	Interpreter services	Article VIII.D.(2)
Upon request	Nursing home relocations	Article VII.C.(4)
Within 60 days of External Review's identification of adverse health situation	Corrective action plan	Protocol, pg. 115

The MCO shall submit reports required under this contract, by the due dates indicated above, to:

AA/CRC
Department of Health and Family Services
Affirmative Action/Civil Rights Compliance Office
P.O. Box 7850
Madison, WI 53707-7850

BLTS-MCS
Department of Health and Family Services
Division of Disability and Elder Services
Bureau of Long-Term Support - Managed Care Section
1 West Wilson, Room 518
PO Box 7851
Madison, WI 53707-7851

EDS - MEDS
EDS - MEDS
10 East Doty Street, Suite 200
Madison, WI 53703

EDS - Olin
EDS
Attn: Managed Care
P.O. Box 6470
Madison, WI 53716-0470

ADDENDUM V

COB REPORT FORMAT

Name of Partnership Organization _____

Mailing Address _____

Office Telephone _____ _____

Provider Number _____ _____

Please designate below the quarter period for which information is given in this report.

_____, 20____ through _____, 20_____

INSTRUCTIONS

For the purposes of this report, an enrollee is any Medicaid recipient listed on the monthly enrollment reports coming from the fiscal agent, and who is an ADD or CONTINUE.

Subrogation may include collections from auto, homeowners, or malpractice insurance, as well as restitution payments from the Division of Corrections. In addition, subrogation should include collections from Workers' Compensation.

Birth costs are not a third party right, and consequently are not included in this report.

Coordination of Benefits Reports are to be completed on a calendar quarterly basis.

The report is to be aggregated for all separate service areas if the MCO has more than one service area.

Please complete and return this report within forty-five (45) days of the end of the quarter being reported to:

Department of Health and Family Services
Division of Disability and Elder Services
Bureau of Long-Term Support - Managed Care Section
1 West Wilson, Room 518
PO Box 7851
Madison, WI 53707-7851

Attn: COB Report from _____ MCO

COB REPORT

The following information is **REQUIRED** in order to comply with CMS reporting requirements:

Cost Avoidance

Indicate the dollar amount of the claims you denied as a result of your knowledge of other insurance being available for the enrollee. The provider did not indicate at the time of the claim submission (with an EOB, etc.) that the other insurance was billed prior to submitting the claim to you. Therefore, you denied the claim. Please indicate the dollar amount of these denials.

Dollar Amount Cost Avoided: _____

Recoveries (Post-Pay Billing/Pay and Chase)

Indicate the dollar amount you received as a result of billing an enrollee's other insurance.

Dollar Amount Collected From Other Insurance: _____

Subrogation/Worker's Compensation
Recoveries (Dollars) This Quarter: _____

I HEREBY CERTIFY that to the best of my knowledge and belief, the information contained in this report is a correct and complete statement prepared from the records of the MCO, except as noted on the report.

Signed: _____
Original Signature of Director or Administrator

Title: _____

Date Signed: _____

ADDENDUM VI

ACTUARIAL BASIS

The actuarial basis for the contract year 2006 capitation rates for the MCO were developed by the Department with assistance from PricewaterhouseCooper, LLP.

The SNF/ICF capitation rate for the MCO has been calculated to cover nursing facility, physician, and all other mandatory and optional services.

Wisconsin Partnership Program

CY 2006 Capitation Rate Development

Partnership Health Plan

	Chippewa, Dunn, & Eau Claire; Elderly		
	SNF/ICF		ISN
	NH	Waiver	NH
Subtotal Acute & Primary Services	**$ 240.62**	**$ 134.50**	**$ 436.51**
Admin	**$ 10.86**	**$ 6.07**	**$ 19.71**
Total Acute & Primary Services	**$ 251.48**	**$ 140.57**	**$ 456.22**
Long-term Care Services	**$ 2,974.23**	**$ 1,318.64**	**$ 3,531.12**
Admin	**$ 134.29**	**$ 99.25**	**$ 159.43**
Total Long-Term Care Services	**$ 3,108.51**	**$ 1,417.90**	**$ 3,690.55**
Total All Services	**$ 3,360.00**	**$ 1,558.47**	**$ 4,146.77**
Less: Managed Care Savings	**$ 168.00**	**$ 77.92**	**$ 207.34**
Total Adjusted Cost	**$ 3,192.00**	**$ 1,480.55**	**$ 3,939.44**
Population Weights	**80.90%**	**19.10%**	**100.00%**
2006 Capitation Rate	**$ 2,865.11**		**$ 3,939.44**

Wisconsin Partnership Program

CY 2006 Capitation Rate Development

Partnership Health Plan

	Chippewa, Dunn, & Eau Claire; PD		
	SNF/ICF		ISN
	NH	Waiver	NH
Subtotal Acute & Primary Services	$ 771.31	$ 682.58	$ 1,152.55
Admin	$ 34.83	$ 30.82	$ 52.04
Total Acute & Primary Services	$ 806.14	$ 713.40	$ 1,204.59
Long-term Care Services	$ 3,159.75	$ 1,910.27	$ 4,516.13
Admin	$ 142.66	$ 143.78	$ 203.91
Total Long-Term Care Services	$ 3,302.41	$ 2,054.05	$ 4,720.03
Total All Services	$ 4,108.55	$ 2,767.45	$ 5,924.62
Less: Managed Care Savings	$ 205.43	$ 138.37	$ 296.23
Total Adjusted Cost	$ 3,903.12	$ 2,629.08	$ 5,628.39
Population Weights	39.70%	60.30%	100.00%
2006 Capitation Rate	$ 3,134.87		$ 5,628.39

ADDENDUM VII

AFFIRMATIVE ACTION (AA), EQUAL OPPORTUNITY, AND CIVIL RIGHTS COMPLIANCE (CRC)

The CRC Plan contains three (3) components: Affirmative Action, Civil Rights/Equal Opportunity, and Language Access. If the MCO has more than 25 employees and receives more than $25,000 from the Department, the MCO must submit an AA, Equal Opportunity, CRC and Language Access Plan. If the MCO has less than 25 employees and receives less than $25,000 from the Department, the MCO must submit a Letter of Assurance and proof it is exempt from submitting Affirmative Action information in accordance with s. 16.675, Wis., Stats, and Adm. Code 50. The MCO must submit language access information as part of the MCO certification application.

1. Affirmative Action Plan

    a. The MCO is exempt from submitting AA Component of the CRC Plan if:

        i. The MCO receives a State contract for less than $25,000 and the MCO has less than 25 employees regardless of the dollar amount of the contract;
        ii. The MCO is a foreign company with a workforce of less than 25 employees in the U.S.;
        iii. The MCO is a federal government agency or a Wisconsin municipality; or,
        iv. The MCO has a balanced workforce, as defined in Article I of this contract.

b. If the MCO is exempt from submitting an AA component because it has a balanced work force, the MCO must submit its "Work Force Analysis Form", as required in the Department's CRC Plan: Instruction and Format.
c. If the MCO is exempt from submitting an AA component for other reasons, the MCO must submit a Request for Exemption from Submitting an AA Component.
d. The AA component must be prepared in accordance with the most recently revised Department CRC plan: Instructions and Format.
e. In addition to submitting the CRC Plan, organizations with 25 employees and agreements with the Department of at least $25000, the MCO shall conduct, keep on file, and update annually, a separate and additional accessibility self-evaluation of all programs and facilities, including employment practices for compliance with the Americans with Disabilities (ADA) Title I regulations, unless an updated self-evaluation under s. 503 of the Rehabilitation Act of 1973 exists that meets the ADA requirements. For technical assistance on all aspects of the Civil Rights Compliance, the MCO is to contact the Department's AA/CRC Office at:

Department of Health and Family Services
1 W. Wilson Street, Room 555
P.O. Box 7850
Madison, WI 53707-7850
(608) 266-9372 (voice)
(608) 266-2555 (TTY)

2. Civil Rights Compliance (CRC) Plan

a. The MCO must comply with state and federal Civil Rights Compliance requirements.
b. The CRC Plan that the MCO submits to the Department's AA/CRC Office attests to how the MCO has complied with all equal opportunity requirements under Title VI and VII of the Civil Rights Act of 1964; ss. 503 and 504 of the Rehabilitation Act of 1973; Title VI and XVI of the Public Health Service Act; the Age Discrimination in Employment Act of 1967; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981; the Americans with Disabilities Act of 1990; and, the Wisconsin Fair Employment Act. If a CRC Plan was submitted and approved during the previous year, a Plan update must be submitted for this contract period.

3. CRC Requirements

a. The MCO agrees to implement and monitor the following policies:

i. No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination in any manner on the basis of race, color, national origin, sexual orientation, religion, sex, or disability of age. This policy covers eligibility for and access to service delivery, and treatment in all programs and activities. All employees of the MCO are expected to support goals and programmatic activities relating to nondiscrimination in service delivery.

ii. No otherwise qualified person shall be excluded from employment, be denied the benefits of employment or otherwise be subject to discrimination in employment in any manner or term of employment on the basis of age, race/ethnicity, religion, sexual orientation, color, sex, national origin or ancestry, disability (as defined in s. 504 of the Rehab Act and the ADA) arrest or conviction record, marital status, political affiliation, military participation, the use of legal products during non-work hours, non-job related genetic and honesty testing. All employees are expected to support goals and programmatic activities relating to non-discrimination in employment.

iii. The MCO will post the Equal Opportunity Policy, the name of the Equal Opportunity Coordinator and the discrimination complaint process in conspicuous places available to applicants and clients of services, and applicants for reemployment and employees. The complaint process will be according to Department standards and made available in languages and formats understandable to enrollees, applicants, and employees. The Department will continue to provide appropriate translated program brochures and forms for distribution.

b. The MCO also agrees to the following:

i. The MCO agrees to comply with all of the requirements in the revised Department CRC Plan for Profit and Non Profit Entities and their subcontractors.

ii. These requirements apply to any subcontracts or grants. The MCO has responsibility for ensuring that its subcontractors or sub-grantees also comply with all of the requirements of the CRC Plan.

iii. The Department will monitor the Civil Rights Compliance of the MCO. The Department will conduct reviews to ensure that the MCO is ensuring compliance by its subcontractors or subgrantees according to the guidelines in the CRC Plan. The MCO agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the MCO, as well as interviews with staff, clients, and applicants for services, subcontractors, grantees, and referral agencies. The reviews will be conducted according to Department procedures. The Department will also conduct reviews to address immediate concerns of complainants.

iv. The MCO agrees to cooperate with the Department in developing, implementing and monitoring corrective action plans that result from complaint investigations or monitoring efforts.

ADDENDUM VIII

MANAGED CARE ORGANIZATION PERSONAL INJURY SETTLEMENTS

Name of Recipient and MA ID Number	Date TPL Payment Received	If Available		Payer
		Attorney Name	Amt. Received	
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Mail this Form to: Department of Health and Family Services
Division of Disability and Elder Services
Bureau of Long-Term Support - Managed Care Section
1 West Wilson, Room 518
PO Box 7851
Madison, WI 53707-7851

ADDENDUM IX

PAYMENT SCHEDULE

Benefit Month	Adverse Action / CARES Cutoff	Initial Enrollment Cycle Reports	Final Enrollment Cycle Reports	Reports Available on FTP Server (By Noon) and Systematic Recoupment Cycle Run	Next Remittance and Status (R&S) Date
1/06	12/16/05 (Fri)	12/19/05 (Mon)		12/20/05 (Tues)	01/08/2006
			12/30/05 (Fri)	1/2/06 (Mon)	
2/06	1/17/06 (Tues)	1/18/06 (Wed)		1/19/06 (Thurs)	02/05/2006
			1/31/06 (Tues)	2/1/06 (Wed)	
3/06	2/15/06 (Wed)	2/16/06 (Thurs)		2/17/06 (Fri)	03/05/2006
			2/28/06 (Tues)	3/1/06 (Wed)	
4/06	3/16/06 (Thurs)	3/17/06 (Fri)		3/20/06 (Mon)	04/09/2006
			3/31/06 (Fri)	4/3/06 (Mon)	
5/06	4/17/06 (Wed)	4/18/06 (Tues)		4/19/06 (Wed)	05/07/2006
			4/28/06 (Fri)	5/1/06 (Mon)	
6/06	5/18/06 (Thurs)	5/19/06 (Fri)		5/22/06 (Mon)	070/9/2006
			5/31/06 (Wed)	6/1/06 (Thurs)	
7/06	6/16/06 (Fri)	6/19/06 (Mon)		6/20/06 (Tues)	07/09/2006
			6/30/06 (Fri)	7/3/06 (Mon)	
8/06	7/18/06 (Tues)	7/19/06 (Wed)		7/20/06 (Thurs)	08/06/2006
			7/31/06 (Mon)	8/1/06 (Tues)	
9/06	8/17/06 (Thurs)	8/18/06 (Fri)		8/21/06 (Mon)	09/03/2006
			8/31/06 (Thurs)	9/1/06 (Fri)	
10/06	9/15/06 (Fri)	9/18/06 (Mon)		9/19/06 (Tues)	10/08/2006
			9/29/06 (Fri)	10/2/06 (Mon)	
11/06	10/17/06 (Tues)	10/18/06 (Wed)		10/19/06 (Thurs)	11/05/2006
			10/31/06 (Tues)	11/1/06 (Wed)	
12/06	11/16/06 (Thurs)	11/17/06 (Fri)		11/20/06 (Mon)	12/03/2006
			11/30/06 (Thurs)	12/1/06 (Fri)	
1/07	12/18/06 (Mon)	12/19/06 (Tues)		12/20/06 (Wed)	01/07/2007
			12/29/06 (Fri)	1/2/07 (Tues)	

- Payment may be received on dates other than those listed. Typically payment will be received the week following the R&S Date. *June payments may be withheld until July due to legislative intent expressed in the state biennial budget.
- Initial recoupments for all MCP codes will be processed after the initial monthly cycle.
- Report dates reflect the actual cycle date; receipt will depend on transfer medium.
- Dates are subject to change due to holiday schedules.
- When the recoupment cycle runs on a Monday, actual recoupments will appear on the following week's R&S statement.
- FTP availability is subject to change.

ADDENDUM X

PERFORMANCE IMPROVEMENT PROJECTS

FORMAT A
EXECUTIVE SUMMARY OUTLINE*

Date _____

Organization _____

Person(s) Completing Executive Summary _____

Title(s) _____ Telephone _____

A. Health or Psychosocial Service Delivery Area of Concern

1. Study Topic. (Briefly define problem; explain its impact on participants' health.)

2. Methods used to identify need for QI study.

3. Are there guidelines, standards, QI indicators, and/or protocol related to the study topic?

4. If yes, attach copy.

B. Identification of Population and Sample

1. Describe the population at-risk, in terms of size of population and age, sex, race/ ethnicity, risk factors/conditions, as appropriate.

2. Describe the risk level of participants.

3. Time frame of the study.

4. Describe how the sample was selected.

5. Sample size.

C. Data Collection

1. Describe data sources. (Include dimensions of the problem as perceived by staff, relatives and participants, when appropriate.)

2. Describe collection methods that may include consultations, interviews, chart reviews and/or physical exams.

3. Describe data retrieval process and attach a copy of the data collection tool.

D. Data Analysis and Interpretation

1. Describe or attach copy of the study findings.

2. Describe or attach a treatment plan summary for individuals according to their normal or high levels of risk in order to prevent and/or reduce risk.

3. Describe or attach copy of the follow-up plan and any continuous quality improvement strategies. (*Include action plan to avoid problem's recurrence.)*

4. Will this topic be restudied or continuously monitored?

5. If yes, describe plans for the next study and for any changes in the study design.

*Attach each QI study using this ADDENDUM X, FORMAT A, as the cover page.

PERFORMANCE IMPROVEMENT PROJECTS

SPECIAL MANAGED CARE PROGRAMS
PERFORMANCE IMPROVEMENT PROJECT REPORT*

FORMAT B

Answer the following ten (10) questions in narrative format. Attach tables, graphs, specifications and appendices as appropriate.

1. In a single sentence, state the question your study answers. Ideally, it should be stated in such a way that the data you collect and analyze provides an unequivocal answer.

2. Explain why you selected this topic.

   - Consider whether you are studying a condition that is prevalent in your patients. If it is not Wisconsin has a web based system for determining functional eligibility. The site completes the screening tool and eligibility is determined via an algorithm within the application. The State has a system of remote quality assurance checks on the information entered on the screen. Prevalent, is it important for some other reasons? These reasons might include a condition of low prevalence but of very serious consequences; or a condition that you have some reason to believe (from internal anecdotes or external literature) can be better managed.

   - If you are studying some infrastructure feature (how referrals are processed, adequacy of transportation, etc.) rather than a particular condition, please relate this feature to the status of your patients.

   Because resources available to do studies are limited, explain why you chose this topic rather than other possible worthy topics.

3. Describe the data you collected to answer the question. Include any data specifications you used. How was the data defined? In what ways was the data limited? If not everybody who could be studied was studied, how did you decide who was in the study and who was out? If eligibility criteria were used, why did you set the particular eligibility standard? How many potential patients were lost to the study because of this eligibility standard or other exclusion criteria?

4. Describe the data collection method. What was the source of the data? If data collection required expert judgment, explain how you know the expert judgment was accurate. Consider issues such as the general professional training of the data collector, and specific training provided for data collection. If more than one person collected data and data collection required expert judgment, how do you know the data collectors made the same judgments?

5. Did you use some standard or norm to set expectations in your study? If yes, what standards were used? Were they from an external source such as a professional guideline or were they internal standards such as last year's performance. Explain why the standard you selected applies to your program, your study, or your patients?

6. What were your results? How did you relate your findings to any standard (if used) and to your study question? What "numbers" resulted from your study? If your study did not produce quantifiable measurements, please explain. Did your results lend themselves to the statistical analysis? If yes, please explain the tests used and the meaning of their results. In a single statement, what answer does the data collected and analyzed make to the study question? Are there any other ways to interpret the data? Please explain.

7. What were the limitations of your study? These may include any difficulties encountered as part of data collection or competing ways to interpret the findings. Consider if the conclusion applies to other programs, all your patients within your program, all your patients with a particular condition or need, only those patients you studied, or patients in other programs.

8. What would you do differently to study the same question next time? Do the findings from your study suggest that the study question might be better answered using a different approach? If so, what approach?

9. What are the next steps, if any, to study this question/topic? What additional questions did your study raise?

10. What will you do differently as a result of your study? What findings from this study will be useful to you in changing your organization's management of patient care? What changes will occur as a result of this study that will significantly improve the quality of services you offer?

*Attach each QI study using this ADDENDUM X, FORMAT B, as the cover page.

ADDENDUM XI

AIDS/VENTILATOR DEPENDENT REPORT FORMAT

A. Report Formats. The MCO shall submit the following report in hard copy format and in Microsoft® Excel or tab delimited text format on an ad hoc quarterly basis:

Managed Care Organization
AIDS/Ventilator Dependent Report – Excluding Long-Term Care Service Costs
[Report Date]

[Member Name] [Medicaid ID #]

Provider Name	Provider Medicaid ID #	Diagnosis Code	Procedure/ Drug Code	Procedure/ Drug Description	From DOS	To DOS	Units	Total Amount Billed	Amount Paid for Medicare-Covered Service	Amount Paid for Medicaid-Covered Service
						Total				

B. Report Field Descriptions.

Field Name	Description
Report Date	Date report was completed.
Member Name	First, MI, and Last name of member.
Medicaid ID #	Member's Medicaid identification number.
Provider Name	Name of provider
Provider Medicaid ID #	Provider's Medicaid identification number.
Diagnosis Code	ICD-9 code.
Procedure/Drug Code	CPT or national drug Code.
Procedure/Drug Description	Description of procedure or drug.
From DOS	From date of service, expressed as yyyymmdd.
To DOS	To date of service, expressed as yyyymmdd.
Units	Quantity of units of service.
Total Amount Billed	Total amount billed by provider for Medicaid and Medicare services.
Amount Paid for Medicare-Covered Service	Amount the MCO paid to provider for Medicare-covered portion of the procedure/drug.
Amount Paid for Medicaid-Covered Service	Amount the MCO paid to provider for Medicaid-covered portion of the procedure/drug.